

**Greene County General Hospital  
Linton, Indiana**

**Provider No's. 15-1317, 15-Z317 and AIM No. 100269150**

**Hospital Statements of Reimbursable Costs  
(Medicare and Medicaid programs)**

**December 31, 2012**

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: 151317	Period: From 01/01/2012 To 12/31/2012	Worksheet 5 Parts I-III Date/Time Prepared: 5/30/2013 11:57 am
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**PART I - COST REPORT STATUS**

Provider use only

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

Date: 5/30/2013 Time: 11:57 am

Contractor use only

5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  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 GREENE COUNTY GENERAL HOSPITAL ( 151317 ) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 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.

**Encryption Information**

ECR: Date: 5/30/2013 Time: 11:57 am  
 Ltf6shmqXq6.:2twa1QUW.PCCRM1D0  
 qNEIkOPI5enc14ty1kumera4KSjd7M  
 f1B303t.Cm0ihN4j

PI: Date: 5/30/2013 Time: 11:57 am  
 tDnsDZTFzgg:Thxp2WLHJNO1GT8Ca0  
 yc24f0M8pJn1xZ:sAfw.rzWIkGpA5I  
 zw1o08KLUM0ouk8:

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	471,138	-553,462	0	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	48,641	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	519,779	-553,462	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151317

Period: From 01/01/2012 To 12/31/2012

Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 10:22 am

		1.00	2.00	3.00	4.00						
<b>Hospital and Hospital Health Care Complex Address:</b>											
1.00	Street: R.R. 1	PO Box: 1000								1.00	
2.00	City: LINTON	State: IN		Zip Code: 47441-9457		County: GREENE				2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
<b>Hospital and Hospital-Based Component Identification:</b>											
3.00	Hospital	GREENE COUNTY GENERAL HOSPITAL		151317	99915	1	02/01/2003	N	O	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	GREENE COUNTY GENERAL HOSPITAL		152317	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)						9		21.00		
<b>Inpatient PPS Information</b>											
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.						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.						0		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

		Beginning:	Ending:		
		1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00	
		Y/N	Y/N		
		1.00	2.00		
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			39.00	
		V	XVIII	XIX	
		1.00	2.00	3.00	
<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	61.00
<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	
<b>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.</b>					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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Period:  
From 01/01/2012  
To 12/31/2012

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	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	
<b>Inpatient Psychiatric Facility PPS</b>					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	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		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		97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y			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	Y	Y	N
		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
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.	Y			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:	118,934	0		0118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<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		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:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151317		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 10:22 am		
							1.00	
<b>Multicampus</b>								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
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)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

		Y/N	Date	
		1.00	2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
<b>Financial Data and Reports</b>				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
<b>Approved Educational Activities</b>				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
<b>Bad Debts</b>				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y
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
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
<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	05/01/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<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			Y	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.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	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.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			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.	WADE		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3172375500		WADEH@BRADLEYCPA.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	05/01/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<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.	PARTNER	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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet S-2  
Part V  
Date/Time Prepared:  
5/30/2013 10:22 am

		1.00	
<b>Cost Report Preparer Contact Information</b>			
1.00	First Name	WADE	1.00
2.00	Last Name	HILL	2.00
3.00	Title	PARTNER	3.00
4.00	Employer	BRADELY ASSOCIATES	4.00
5.00	Phone Number	(317)237-5500	5.00
6.00	E-mail Address	WADEH@BRADLEYCPA.COM	6.00
7.00	Department		7.00
8.00	Mailing Address 1	201 S. CAPITOL AVE	8.00
9.00	Mailing Address 2	SUITE 910	9.00
10.00	City	INDIANAPOLIS	10.00
11.00	State	IN	11.00
12.00	Zip	46225	12.00
<b>Officer or Administrator of Provider Contact Information</b>			
13.00	First Name	TIM	13.00
14.00	Last Name	NORRIS	14.00
15.00	Title		15.00
16.00	Employer	GREENE COUNTY GENERAL HOSPITAL	16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2		21.00
22.00	City	LINTON	22.00
23.00	State	IN	23.00
24.00	Zip		24.00

		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		<b>Inpatient</b>	<b>Outpatient</b>	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		<b>Title V</b>	<b>Title XIX</b>	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	20	7,320	56,664.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,320	56,664.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,830	5,472.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	62,136.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents	
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
	6.00	7.00	8.00	9.00	10.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,718	64	2,361		1.00
2.00 HMO	0	103			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	260	0	260		5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	6		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,978	64	2,627		7.00
8.00 INTENSIVE CARE UNIT	199	3	228		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		73	140		13.00
14.00 Total (see instructions)	2,177	140	2,995	0.00	14.00
15.00 CAH visits	0	0	0		15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25

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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00			652			28.00
29.00	0					29.00
30.00			0			30.00
31.00			0			31.00
32.00		0	0			32.00
33.00	0					33.00
Component	Discharges					
	Full Time Equivalents	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)					1.00
2.00			559	74	809	2.00
3.00			0			3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	0.00	0	559	74	809	14.00
15.00						15.00
16.00						16.00
17.00						17.00
18.00						18.00
19.00						19.00
20.00						20.00
21.00						21.00
22.00						22.00
23.00						23.00
24.00						24.00
25.00						25.00
26.00						26.00
26.25						26.25
27.00	0.00					27.00
28.00						28.00
29.00						29.00
30.00						30.00
31.00						31.00
32.00						32.00
33.00						33.00

		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)	0.453811	1.00
<b>Medicaid (see instructions for each line)</b>			
2.00	Net revenue from Medicaid	1,084,093	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	294,781	5.00
6.00	Medicaid charges	6,589,604	6.00
7.00	Medicaid cost (line 1 times line 6)	2,990,435	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)	1,611,561	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
<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)	1,611,561	19.00
		<b>Uninsured patients</b>	<b>Insured patients</b>
		<b>1.00</b>	<b>2.00</b>
		<b>Total (col. 1 + col. 2)</b>	<b>3.00</b>
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	796,897	248,411
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	361,641	112,732
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	361,641	112,732
		<b>1.00</b>	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,466,547	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	419,910	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,046,637	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,382,597	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,856,970	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,468,531	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A

Date/Time Prepared:  
5/30/2013 10:22 am

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 NEW CAP REL COSTS-BLDG & FIXT		310,298	310,298	36,918	347,216	1.00		
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		210,758	210,758	2,974	213,732	2.00		
4.00 00400 EMPLOYEE BENEFITS	0	3,113,307	3,113,307	11,948	3,125,255	4.00		
5.00 00500 ADMINISTRATIVE & GENERAL	1,050,557	2,048,637	3,099,194	-15,837	3,083,357	5.00		
7.00 00700 OPERATION OF PLANT	348,552	937,254	1,285,806	0	1,285,806	7.00		
8.00 00800 LAUNDRY & LINEN SERVICE	0	150,688	150,688	0	150,688	8.00		
9.00 00900 HOUSEKEEPING	314,149	69,813	383,962	0	383,962	9.00		
10.00 01000 DIETARY	448,417	466,656	915,073	-818,681	96,392	10.00		
11.00 01100 CAFETERIA	0	0	0	756,928	756,928	11.00		
13.00 01300 NURSING ADMINISTRATION	531,058	76,618	607,676	0	607,676	13.00		
14.00 01400 CENTRAL SERVICES & SUPPLY	0	7,778	7,778	0	7,778	14.00		
15.00 01500 PHARMACY	641,555	84,752	726,307	0	726,307	15.00		
16.00 01600 MEDICAL RECORDS & LIBRARY	209,096	24,049	233,145	0	233,145	16.00		
17.00 01700 SOCIAL SERVICE	120,935	0	120,935	0	120,935	17.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00 03000 ADULTS & PEDIATRICS	2,544,781	69,388	2,614,169	4,465	2,618,634	30.00		
31.00 03100 INTENSIVE CARE UNIT	673,294	26,810	700,104	0	700,104	31.00		
43.00 04300 NURSERY	27,417	149	27,566	0	27,566	43.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000 OPERATING ROOM	373,872	214,817	588,689	0	588,689	50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1,725	1,725	21,285	23,010	52.00		
53.00 05300 ANESTHESIOLOGY	377,105	11,140	388,245	0	388,245	53.00		
54.00 05400 RADIOLOGY-DIAGNOSTIC	906,612	790,121	1,696,733	0	1,696,733	54.00		
60.00 06000 LABORATORY	742,251	1,415,774	2,158,025	0	2,158,025	60.00		
65.00 06500 RESPIRATORY THERAPY	468,800	39,600	508,400	0	508,400	65.00		
66.00 06600 PHYSICAL THERAPY	309,810	16,203	326,013	-33,977	292,036	66.00		
67.00 06700 OCCUPATIONAL THERAPY	61,167	0	61,167	33,977	95,144	67.00		
68.00 06800 SPEECH PATHOLOGY	8,445	0	8,445	0	8,445	68.00		
69.00 06900 ELECTROCARDIOLOGY	27,139	42,453	69,592	0	69,592	69.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	279,121	279,121	-6,810	272,311	71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,810	6,810	72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,314,581	1,314,581	0	1,314,581	73.00		
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00 09100 EMERGENCY	365,457	1,388,335	1,753,792	0	1,753,792	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00		
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		10,550,469	13,110,825	23,661,294	0	23,661,294	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00	
194.00 07950 FOUNDATION/ MOBS	0	0	0	0	0	0	194.00	
200.00	TOTAL (SUM OF LINES 118-199)		10,550,469	13,110,825	23,661,294	0	23,661,294	200.00
<b>Adjustments and Net Expenses</b>								
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	-44,734	302,482					1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	-55,354	158,378					2.00	
4.00 00400 EMPLOYEE BENEFITS	390,016	3,515,271					4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	763,192	3,846,549					5.00	
7.00 00700 OPERATION OF PLANT	0	1,285,806					7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	150,688					8.00	
9.00 00900 HOUSEKEEPING	0	383,962					9.00	
10.00 01000 DIETARY	0	96,392					10.00	
11.00 01100 CAFETERIA	-258,770	498,158					11.00	
13.00 01300 NURSING ADMINISTRATION	0	607,676					13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	7,778					14.00	
15.00 01500 PHARMACY	0	726,307					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	-6,634	226,511					16.00	
17.00 01700 SOCIAL SERVICE	0	120,935					17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00 03000 ADULTS & PEDIATRICS	0	2,618,634					30.00	
31.00 03100 INTENSIVE CARE UNIT	0	700,104					31.00	
43.00 04300 NURSERY	0	27,566					43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000 OPERATING ROOM	0	588,689					50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	23,010					52.00	
53.00 05300 ANESTHESIOLOGY	0	388,245					53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	-2,543	1,694,190					54.00	
60.00 06000 LABORATORY	-40,000	2,118,025					60.00	
65.00 06500 RESPIRATORY THERAPY	0	508,400					65.00	

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
66.00	06600 PHYSICAL THERAPY	0	292,036	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	95,144	67.00
68.00	06800 SPEECH PATHOLOGY	0	8,445	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69,592	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	272,311	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,810	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,314,581	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	-846,718	907,074	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-101,545	23,559,749	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950 FOUNDATION/ MOBS	925,611	925,611	194.00
200.00	TOTAL (SUM OF LINES 118-199)	824,066	24,485,360	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet Non-CMS W

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	FOUNDATION/ MOBS	07950		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - INSURANCE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36,918	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,974	2.00
3.00	EMPLOYEE BENEFITS	4.00	0	11,948	3.00
	TOTALS		0	51,840	
<b>B - LABOR &amp; DELIVERY</b>					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	21,285	0	1.00
	TOTALS		21,285	0	
<b>C - DIETARY/ CAFETERIA</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	30,261	31,492	1.00
2.00	CAFETERIA	11.00	370,921	386,007	2.00
	TOTALS		401,182	417,499	
<b>D - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	6,810	1.00
	TOTALS		0	6,810	
<b>E - OT &amp; ST CONTRACTED SERVICES</b>					
1.00	OCCUPATIONAL THERAPY	67.00	0	61,167	1.00
2.00	SPEECH PATHOLOGY	68.00	0	5,957	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	67,124	
<b>F - OB RECLASS</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	25,750	1.00
	TOTALS		0	25,750	
500.00	Grand Total: Increases		422,467	569,023	500.00

		Decreases					
Cost Center	Line #	Salary	Other	10.00	12	12	
6.00	7.00	8.00	9.00	10.00	11.00	12.00	
<b>A - INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,840	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	51,840			
<b>B - LABOR &amp; DELIVERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	21,285	0	0		1.00
	TOTALS		21,285	0			
<b>C - DIETARY/ CAFETERIA</b>							
1.00	DIETARY	10.00	401,182	417,499	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		401,182	417,499			
<b>D - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,810	0		1.00
	TOTALS		0	6,810			
<b>E - OT &amp; ST CONTRACTED SERVICES</b>							
1.00	OCCUPATIONAL THERAPY	67.00	27,190	0	0		1.00
2.00	SPEECH PATHOLOGY	68.00	5,957	0	0		2.00
3.00	PHYSICAL THERAPY	66.00	33,977	0	0		3.00
	TOTALS		67,124	0			
<b>F - OB RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,750	0		1.00
	TOTALS		0	25,750			
500.00	Grand Total: Decreases		489,591	501,899			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - INSURANCE</b>						
1.00						
NEW CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00						
NEW CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0	2.00
3.00						
EMPLOYEE BENEFITS	4.00	0		0.00	0	3.00
TOTALS		0	TOTALS		0	
<b>B - LABOR &amp; DELIVERY</b>						
1.00						
DELIVERY ROOM & LABOR ROOM	52.00	21,285	ADULTS & PEDIATRICS	30.00	21,285	1.00
TOTALS		21,285	TOTALS		21,285	
<b>C - DIETARY/ CAFETERIA</b>						
1.00						
ADMINISTRATIVE & GENERAL	5.00	30,261	DIETARY	10.00	401,182	1.00
2.00						
CAFETERIA	11.00	370,921		0.00	0	2.00
TOTALS		401,182	TOTALS		401,182	
<b>D - IMPLANTABLE DEVICES</b>						
1.00						
IMPL. DEV. CHARGED TO PATIENT	72.00	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1.00
TOTALS		0	TOTALS		0	
<b>E - OT &amp; ST CONTRACTED SERVICES</b>						
1.00						
OCCUPATIONAL THERAPY	67.00	0	OCCUPATIONAL THERAPY	67.00	27,190	1.00
2.00						
SPEECH PATHOLOGY	68.00	0	SPEECH PATHOLOGY	68.00	5,957	2.00
3.00						
	0.00	0	PHYSICAL THERAPY	66.00	33,977	3.00
TOTALS		0	TOTALS		67,124	
<b>F - OB RECLASS</b>						
1.00						
ADULTS & PEDIATRICS	30.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
TOTALS		0	TOTALS		0	
500.00						
Grand Total: Increases		422,467	Grand Total: Decreases		489,591	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	759,198	0	0	0	0	1.00
2.00	Land Improvements	425,781	0	0	0	0	2.00
3.00	Buildings and Fixtures	7,255,971	0	0	0	82,699	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	849,692	85,387	0	85,387	0	5.00
6.00	Movable Equipment	3,296,254	312,296	0	312,296	0	6.00
7.00	HIT designated Assets	209,341	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,796,237	397,683	0	397,683	82,699	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,796,237	397,683	0	397,683	82,699	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	759,198	0				1.00
2.00	Land Improvements	425,781	0				2.00
3.00	Buildings and Fixtures	7,173,272	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	935,079	0				5.00
6.00	Movable Equipment	3,608,550	0				6.00
7.00	HIT designated Assets	209,341	0				7.00
8.00	Subtotal (sum of lines 1-7)	13,111,221	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	13,111,221	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	310,298	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	210,758	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	521,056	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<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	310,298				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	210,758				2.00
3.00	Total (sum of lines 1-2)	0	521,056				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	7,173,272	0	7,173,272	0.665312	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,608,550	0	3,608,550	0.334688	0	2.00
3.00	Total (sum of lines 1-2)	10,781,822	0	10,781,822	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	265,564	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	155,404	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	420,968	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	36,918	0	0	302,482	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,974	0	0	158,378	2.00
3.00	Total (sum of lines 1-2)	0	39,892	0	0	460,860	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #	wkst. A-7 Ref.	
				Cost Center	Line #			
		1.00	2.00	3.00	4.00	5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-44,734		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-17,802		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)			0		0.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-886,718				0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-13,484		NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,315,627				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-258,770		CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,634		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines			0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	SALE OF X RAY FILM	B	-2,543		RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01	CPR TRAINING	B	-978		ADMINISTRATIVE & GENERAL	5.00	0	33.01

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Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-8

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		wkst. A-7	Ref.
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
33.02 MISC INCOME	B	-2,194	ADMINISTRATIVE & GENERAL	5.00		0 33.02
33.03 MISC NON-ALLOWABLE EXPENSE	A	-13,485	ADMINISTRATIVE & GENERAL	5.00		0 33.03
33.04 AHA DUES	A	-2,094	ADMINISTRATIVE & GENERAL	5.00		0 33.04
33.05 IHA DUES	A	-745	ADMINISTRATIVE & GENERAL	5.00		0 33.05
33.06 MARKETING & ADVERTISING	A	-88,280	ADMINISTRATIVE & GENERAL	5.00		0 33.06
33.07 PHYSICIAN RECRUITING	A	-6,000	ADMINISTRATIVE & GENERAL	5.00		0 33.07
33.08		0		0.00		0 33.08
33.09 2011 HIT ADDITIONS DEPR EXPENSE	A	-41,868	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 33.09
33.10 LOSS ON DISPOSAL DEPR	A	-2	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 33.10
33.11		0		0.00		0 33.11
33.12 HOSPITAL ASSESSMENT FEE	A	894,770	ADMINISTRATIVE & GENERAL	5.00		0 33.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		824,066				50.00

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

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:  
5/30/2013 10:22 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	194.00	FOUNDATION/ MOBS	925,611	0	1.00
2.00	4.00	EMPLOYEE BENEFITS	390,016	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0		1,315,627	0	5.00

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

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

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

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

6.00	C	GCGH FOUNDATION	0.00	0.00	6.00
7.00	C	GCH-WORTHINGTON	0.00	0.00	7.00
8.00	C	GCH-BLOOMFIELD	0.00	0.00	8.00
9.00	C	GCGH, LLC	0.00	0.00	9.00
10.00	C	GC HOME HEALTH	0.00	0.00	10.00
10.01	C	GCH-LINTON	0.00	0.00	10.01
10.02	C	LINTON MD CLIN	0.00	0.00	10.02
10.03	C	LONE TREE CLIN	0.00	0.00	10.03
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-8-1  
Date/Time Prepared:  
5/30/2013 10:22 am

	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	925,611	0	1.00
2.00	390,016	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	1,315,627		5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
10.01		10.01
10.02		10.02
10.03		10.03
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:  
5/30/2013 10:22 am

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,350,288	846,718	503,570	0	0	1.00
2.00	60.00	LABORATORY	40,000	40,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,390,288	886,718	503,570	0	0	200.00

  

	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

  

	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	EMERGENCY	0	0	0	846,718	1.00
2.00	60.00	LABORATORY	0	0	0	40,000	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	886,718	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151317	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 10:22 am
		Occupational Therapy	Cost

			1.00	
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<b>PART I - GENERAL INFORMATION</b>				
1.00	Total number of weeks worked (excluding aides) (see instructions)		32	1.00
2.00	Line 1 multiplied by 15 hours per week		480	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		142	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	0.00	1,120.00	0.00	0.00	0.00	9.00
10.00	0.00	68.25	0.00	0.00	0.00	10.00
11.00	34.13	34.13	0.00			11.00
12.00	0	0	0			12.00
12.01	0	0	0			12.01
13.00	0	0	0			13.00
13.01	0	0	0			13.01

					1.00	
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<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>				
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		76,440	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		76,440	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		76,440	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.				
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		76,440	23.00

**PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE**

<b>Standard Travel Allowance</b>				
24.00	Therapists (line 3 times column 2, line 11)		4,846	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		4,846	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		781	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		5,627	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>				
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		5,627	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		781	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00

**Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE**

<b>Standard Travel Expense</b>				
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>				
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>				
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY  
OUTSIDE SUPPLIERS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-8-3  
Parts I-VI  
Date/Time Prepared:  
5/30/2013 10:22 am

		Speech Pathology					Cost
							1.00
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)						32 1.00
2.00	Line 1 multiplied by 15 hours per week						480 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						49 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0 6.00
7.00	Standard travel expense rate						5.50 7.00
8.00	Optional travel expense rate per mile						0.00 8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	114.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.60	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.80	32.80	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						7,478 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						7,478 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						7,478 20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						65.60 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						31,488 22.00
23.00	Total salary equivalency (see instructions)						31,488 23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)						1,607 24.00
25.00	Assistants (line 4 times column 3, line 11)						0 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						1,607 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						270 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						1,877 28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)						1,877 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						270 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0 35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)						0 36.00
37.00	Assistants (line 6 times column 3, line 11)						0 37.00
38.00	Subtotal (sum of lines 36 and 37)						0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0 39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0 41.00
42.00	Subtotal (sum of lines 40 and 41)						0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0 43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY  
OUTSIDE SUPPLIERS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet A-8-3  
Parts I-VI  
Date/Time Prepared:  
5/30/2013 10:22 am

		Speech Pathology				Cost		
							1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
<b>PART V - OVERTIME COMPUTATION</b>								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
<b>CALCULATION OF LIMIT</b>								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>								
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.60	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>								
57.00	Salary equivalency amount (from line 23)						31,488	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,877	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						33,365	63.00
64.00	Total cost of outside supplier services (from your records)						5,957	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
<b>LINE 33: CALCULATION</b>								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,607	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						270	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,877	100.02
<b>LINE 34: CALCULATION</b>								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						270	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						270	101.02
<b>LINE 35: CALCULATION</b>								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

Cost Center Description	Net Expenses For Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	302,482	302,482			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	158,378		158,378		2.00
4.00 00400	EMPLOYEE BENEFITS	3,515,271	0	0	3,515,271	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,846,549	45,978	24,074	308,182	5.00
7.00 00700	OPERATION OF PLANT	1,285,806	29,119	15,247	99,385	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	150,688	3,922	2,054	0	8.00
9.00 00900	HOUSEKEEPING	383,962	2,888	1,512	89,576	9.00
10.00 01000	DIETARY	96,392	17,804	9,322	13,468	10.00
11.00 01100	CAFETERIA	498,158	10,863	5,688	105,764	11.00
13.00 01300	NURSING ADMINISTRATION	607,676	2,722	1,425	151,425	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,778	4,118	2,156	0	14.00
15.00 01500	PHARMACY	726,307	4,707	2,464	182,932	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	226,511	5,990	3,136	59,621	16.00
17.00 01700	SOCIAL SERVICE	120,935	1,468	769	34,483	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,618,634	53,883	28,211	719,546	30.00
31.00 03100	INTENSIVE CARE UNIT	700,104	15,564	8,149	191,982	31.00
43.00 04300	NURSERY	27,566	3,031	1,587	7,818	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	588,689	25,767	13,492	106,605	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	23,010	12,385	6,484	6,069	52.00
53.00 05300	ANESTHESIOLOGY	388,245	0	0	107,527	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,694,190	18,280	9,571	258,510	54.00
60.00 06000	LABORATORY	2,118,025	11,481	6,012	211,644	60.00
65.00 06500	RESPIRATORY THERAPY	508,400	2,716	1,422	133,673	65.00
66.00 06600	PHYSICAL THERAPY	292,036	4,879	2,555	78,650	66.00
67.00 06700	OCCUPATIONAL THERAPY	95,144	4,879	2,555	9,688	67.00
68.00 06800	SPEECH PATHOLOGY	8,445	1,194	625	709	68.00
69.00 06900	ELECTROCARDIOLOGY	69,592	2,341	1,226	7,738	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	272,311	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	6,810	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,314,581	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	907,074	9,895	5,181	104,206	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,559,749	295,874	154,917	2,989,201	23,023,610
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,147	601	0	1,748
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	5,461	2,860	0	8,321
194.00 07950	FOUNDATION/ MOBS	925,611	0	0	526,070	1,451,681
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	24,485,360	302,482	158,378	3,515,271	24,485,360
<b>Cost Center Description</b>						
		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,224,783				5.00
7.00 00700	OPERATION OF PLANT	298,094	1,727,651			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	32,668	29,800	219,132		8.00
9.00 00900	HOUSEKEEPING	99,661	21,944	14,637	614,180	9.00
10.00 01000	DIETARY	28,565	135,275	5,953	0	306,779
11.00 01100	CAFETERIA	129,382	82,538	0	0	272,125
13.00 01300	NURSING ADMINISTRATION	159,154	20,680	0	50,010	0
14.00 01400	CENTRAL SERVICES & SUPPLY	2,930	31,290	0	5,991	0
15.00 01500	PHARMACY	191,092	35,760	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	61,568	45,513	0	6,512	0
17.00 01700	SOCIAL SERVICE	32,875	11,153	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	713,211	409,392	70,787	237,023	30,804
31.00 03100	INTENSIVE CARE UNIT	190,964	118,253	10,069	55,219	3,850
43.00 04300	NURSERY	8,341	23,028	0	16,409	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	153,170	195,779	27,456	77,619	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet B  
Part I  
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5/30/2013 10:22 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,998	94,097	0	9,637	0	52.00
53.00	05300 ANESTHESIOLOGY	103,379	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	412,988	138,888	22,544	20,316	0	54.00
60.00	06000 LABORATORY	489,435	87,234	0	20,577	0	60.00
65.00	06500 RESPIRATORY THERAPY	134,749	20,634	0	9,898	0	65.00
66.00	06600 PHYSICAL THERAPY	78,846	37,070	17,297	7,554	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	23,410	37,070	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,288	9,076	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	16,869	17,790	0	2,605	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	56,783	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,420	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	274,119	0	0	1,563	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	214,018	75,178	40,040	64,856	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,919,977	1,677,442	208,783	585,789	306,779	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	364	8,714	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,735	41,495	10,349	28,391	0	192.00
194.00	07950 FOUNDATION/ MOBS	302,707	0	0	0	0	194.00
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)	4,224,783	1,727,651	219,132	614,180	306,779	202.00
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 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	1,104,518					11.00
13.00	01300 NURSING ADMINISTRATION	51,968	1,045,060				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	54,263			14.00
15.00	01500 PHARMACY	40,334	0	0	1,183,596		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	39,558	0	0	0	448,409	16.00
17.00	01700 SOCIAL SERVICE	15,513	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	392,477	722,405	0	0	119,757	30.00
31.00	03100 INTENSIVE CARE UNIT	79,891	147,051	0	0	11,567	31.00
43.00	04300 NURSERY	7,756	14,277	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	49,641	91,371	0	0	8,846	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,327	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	127,206	0	0	0	129,283	54.00
60.00	06000 LABORATORY	129,533	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	58,949	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	42,660	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	7,756	0	0	0	178,276	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	52,939	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1,324	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,942	0	0	1,183,596	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	38,007	69,956	0	0	680	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,104,518	1,045,060	54,263	1,183,596	448,409	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,104,518	1,045,060	54,263	1,183,596	448,409	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

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					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
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
		217,196				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	187,238	6,303,368	0	6,303,368	30.00
31.00	03100	25,464	1,558,127	0	1,558,127	31.00
43.00	04300	0	109,813	0	109,813	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	4,494	1,342,929	0	1,342,929	50.00
52.00	05200	0	164,007	0	164,007	52.00
53.00	05300	0	599,151	0	599,151	53.00
54.00	05400	0	2,831,776	0	2,831,776	54.00
60.00	06000	0	3,073,941	0	3,073,941	60.00
65.00	06500	0	870,441	0	870,441	65.00
66.00	06600	0	561,547	0	561,547	66.00
67.00	06700	0	172,746	0	172,746	67.00
68.00	06800	0	22,337	0	22,337	68.00
69.00	06900	0	304,193	0	304,193	69.00
71.00	07100	0	382,033	0	382,033	71.00
72.00	07200	0	9,554	0	9,554	72.00
73.00	07300	0	2,794,801	0	2,794,801	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	0	1,529,091	0	1,529,091	91.00
92.00	09200			0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		217,196	22,629,855	0	22,629,855	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	10,826	0	10,826	190.00
192.00	19200	0	90,291	0	90,291	192.00
194.00	07950	0	1,754,388	0	1,754,388	194.00
200.00			0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		217,196	24,485,360	0	24,485,360	202.00

Provider CCN: 151317

Period:  
 From 01/01/2012  
 To 12/31/2012

Worksheet Non-CMS W  
 Date/Time Prepared:  
 5/30/2013 10:22 am

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS	4	GROSS SALARIES		4.00
5.00	ADMINISTRATIVE & GENERAL	-18	ACCUM. COST		5.00
7.00	OPERATION OF PLANT	3	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY		8.00
9.00	HOUSEKEEPING	9	HOURS OF	SERVICE	9.00
10.00	DIETARY	10	MEALS	SERVED	10.00
11.00	CAFETERIA	11	HOURS		11.00
13.00	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	14.00
15.00	PHARMACY	15	COSTED	REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	16.00
17.00	SOCIAL SERVICE	17	TIME	SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	45,978	24,074	5.00
7.00	00700	OPERATION OF PLANT	0	29,119	15,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,922	2,054	8.00
9.00	00900	HOUSEKEEPING	0	2,888	1,512	9.00
10.00	01000	DIETARY	0	17,804	9,322	10.00
11.00	01100	CAFETERIA	0	10,863	5,688	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,722	1,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,118	2,156	14.00
15.00	01500	PHARMACY	0	4,707	2,464	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,990	3,136	16.00
17.00	01700	SOCIAL SERVICE	0	1,468	769	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	53,883	28,211	30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,564	8,149	31.00
43.00	04300	NURSERY	0	3,031	1,587	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	25,767	13,492	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,385	6,484	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,280	9,571	54.00
60.00	06000	LABORATORY	0	11,481	6,012	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,716	1,422	65.00
66.00	06600	PHYSICAL THERAPY	0	4,879	2,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,879	2,555	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,194	625	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,341	1,226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	EMERGENCY	0	9,895	5,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	295,874	154,917	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,147	601	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,461	2,860	192.00
194.00	07950	FOUNDATION/ MOBS	0	0	0	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	302,482	158,378	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

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Part II  
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Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	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
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	70,052					5.00
7.00	00700 OPERATION OF PLANT	4,943	49,309				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	542	851	7,369			8.00
9.00	00900 HOUSEKEEPING	1,653	626	492	7,171		9.00
10.00	01000 DIETARY	474	3,861	200	0	31,661	10.00
11.00	01100 CAFETERIA	2,146	2,356	0	0	28,085	11.00
13.00	01300 NURSING ADMINISTRATION	2,639	590	0	584	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	49	893	0	70	0	14.00
15.00	01500 PHARMACY	3,169	1,021	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,021	1,299	0	76	0	16.00
17.00	01700 SOCIAL SERVICE	545	318	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	11,816	11,683	2,381	2,768	3,179	30.00
31.00	03100 INTENSIVE CARE UNIT	3,167	3,375	339	645	397	31.00
43.00	04300 NURSERY	138	657	0	192	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,540	5,588	923	906	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	166	2,686	0	113	0	52.00
53.00	05300 ANESTHESIOLOGY	1,714	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,849	3,964	758	237	0	54.00
60.00	06000 LABORATORY	8,116	2,490	0	240	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,235	589	0	116	0	65.00
66.00	06600 PHYSICAL THERAPY	1,308	1,058	582	88	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	388	1,058	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	38	259	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	280	508	0	30	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	942	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	24	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,546	0	0	18	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	3,549	2,146	1,346	757	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,997	47,876	7,021	6,840	31,661	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6	249	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	29	1,184	348	331	0	192.00
194.00	07950 FOUNDATION/ MOBS	5,020	0	0	0	0	194.00
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)	70,052	49,309	7,369	7,171	31,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

Period:  
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To 12/31/2012

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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 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	49,138					11.00
13.00	01300 NURSING ADMINISTRATION	2,312	10,272				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	7,286			14.00
15.00	01500 PHARMACY	1,794	0	0	13,155		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,760	0	0	0	13,282	16.00
17.00	01700 SOCIAL SERVICE	690	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	17,460	7,101	0	0	3,547	30.00
31.00	03100 INTENSIVE CARE UNIT	3,554	1,445	0	0	343	31.00
43.00	04300 NURSERY	345	140	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,208	898	0	0	262	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	104	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,659	0	0	0	3,829	54.00
60.00	06000 LABORATORY	5,763	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,623	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,898	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	345	0	0	0	5,281	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,108	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	178	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	932	0	0	13,155	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	1,691	688	0	0	20	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	49,138	10,272	7,286	13,155	13,282	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 FOUNDATION/ MOBS	0	0	0	0	0	194.00
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)	49,138	10,272	7,286	13,155	13,282	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

Period:  
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Part II  
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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
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	3,790			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	3,268	145,297	0	145,297
31.00	03100	INTENSIVE CARE UNIT	444	37,422	0	37,422
43.00	04300	NURSERY	0	6,090	0	6,090
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	78	52,662	0	52,662
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,938	0	21,938
53.00	05300	ANESTHESIOLOGY	0	1,714	0	1,714
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,147	0	49,147
60.00	06000	LABORATORY	0	34,102	0	34,102
65.00	06500	RESPIRATORY THERAPY	0	9,701	0	9,701
66.00	06600	PHYSICAL THERAPY	0	12,368	0	12,368
67.00	06700	OCCUPATIONAL THERAPY	0	8,880	0	8,880
68.00	06800	SPEECH PATHOLOGY	0	2,116	0	2,116
69.00	06900	ELECTROCARDIOLOGY	0	10,011	0	10,011
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,050	0	8,050
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	202	0	202
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,651	0	18,651
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100	EMERGENCY	0	25,273	0	25,273
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,790	443,624	0	443,624
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,003	0	2,003
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,213	0	10,213
194.00	07950	FOUNDATION/ MOBS	0	5,020	0	5,020
200.00		Cross Foot Adjustments		0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,790	460,860	0	460,860

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet B-1

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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	50,900					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		50,900				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	12,328,310			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,737	7,737	1,080,818	-4,224,783	20,260,577	5.00
7.00 00700	OPERATION OF PLANT	4,900	4,900	348,552	0	1,429,557	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	660	660	0	0	156,664	8.00
9.00 00900	HOUSEKEEPING	486	486	314,149	0	477,938	9.00
10.00 01000	DIETARY	2,996	2,996	47,235	0	136,986	10.00
11.00 01100	CAFETERIA	1,828	1,828	370,921	0	620,473	11.00
13.00 01300	NURSING ADMINISTRATION	458	458	531,058	0	763,248	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	693	693	0	0	14,052	14.00
15.00 01500	PHARMACY	792	792	641,555	0	916,410	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,008	1,008	209,096	0	295,258	16.00
17.00 01700	SOCIAL SERVICE	247	247	120,935	0	157,655	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	9,067	9,067	2,523,496	0	3,420,274	30.00
31.00 03100	INTENSIVE CARE UNIT	2,619	2,619	673,294	0	915,799	31.00
43.00 04300	NURSERY	510	510	27,417	0	40,002	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	4,336	4,336	373,872	0	734,553	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,084	2,084	21,285	0	47,948	52.00
53.00 05300	ANESTHESIOLOGY	0	0	377,105	0	495,772	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,076	3,076	906,612	0	1,980,551	54.00
60.00 06000	LABORATORY	1,932	1,932	742,251	0	2,347,162	60.00
65.00 06500	RESPIRATORY THERAPY	457	457	468,800	0	646,211	65.00
66.00 06600	PHYSICAL THERAPY	821	821	275,833	0	378,120	66.00
67.00 06700	OCCUPATIONAL THERAPY	821	821	33,977	0	112,266	67.00
68.00 06800	SPEECH PATHOLOGY	201	201	2,488	0	10,973	68.00
69.00 06900	ELECTROCARDIOLOGY	394	394	27,139	0	80,897	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	272,311	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	6,810	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,314,581	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100	EMERGENCY	1,665	1,665	365,457	0	1,026,356	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	49,788	49,788	10,483,345	-4,224,783	18,798,827	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	193	193	0	0	1,748	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	919	919	0	0	8,321	192.00
194.00 07950	FOUNDATION/ MOBS	0	0	1,844,965	0	1,451,681	194.00
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)	302,482	158,378	3,515,271		4,224,783	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	5.942672	3.111552	0.285138		0.208522	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		70,052	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.003458	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		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
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	38,263				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	660	24,223			8.00
9.00	00900	HOUSEKEEPING	486	1,618	2,358		9.00
10.00	01000	DIETARY	2,996	658	0	95,139	10.00
11.00	01100	CAFETERIA	1,828	0	0	84,392	11.00
13.00	01300	NURSING ADMINISTRATION	458	0	192	0	67
14.00	01400	CENTRAL SERVICES & SUPPLY	693	0	23	0	0
15.00	01500	PHARMACY	792	0	0	0	52
16.00	01600	MEDICAL RECORDS & LIBRARY	1,008	0	25	0	51
17.00	01700	SOCIAL SERVICE	247	0	0	0	20
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	9,067	7,825	910	9,553	506
31.00	03100	INTENSIVE CARE UNIT	2,619	1,113	212	1,194	103
43.00	04300	NURSERY	510	0	63	0	10
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,336	3,035	298	0	64
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,084	0	37	0	3
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,076	2,492	78	0	164
60.00	06000	LABORATORY	1,932	0	79	0	167
65.00	06500	RESPIRATORY THERAPY	457	0	38	0	76
66.00	06600	PHYSICAL THERAPY	821	1,912	29	0	55
67.00	06700	OCCUPATIONAL THERAPY	821	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	201	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	394	0	10	0	10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6	0	27
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	1,665	4,426	249	0	49
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,151	23,079	2,249	95,139	1,424
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	193	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	919	1,144	109	0	0
194.00	07950	FOUNDATION/ MOBS	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)	1,727,651	219,132	614,180	306,779	1,104,518
203.00		Unit cost multiplier (wkst. B, Part I)	45.152001	9.046443	260.466497	3.224535	775.644663
204.00		Cost to be allocated (per wkst. B, Part II)	49,309	7,369	7,171	31,661	49,138
205.00		Unit cost multiplier (wkst. B, Part II)	1.288686	0.304215	3.041137	0.332787	34.507022

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

Period:  
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To 12/31/2012

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Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRSNG HRS) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00	SOCIAL SERVICE  (TIME SPENT) 17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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	732					13.00
14.00	01400	0	279,121				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	659		16.00
17.00	01700	0	0	0	0	145	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	506	0	0	176	125	30.00
31.00	03100	103	0	0	17	17	31.00
43.00	04300	10	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	64	0	0	13	3	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	190	0	54.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	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	262	0	69.00
71.00	07100	0	272,311	0	0	0	71.00
72.00	07200	0	6,810	0	0	0	72.00
73.00	07300	0	0	100	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	49	0	0	1	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		732	279,121	100	659	145	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	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
200.00							200.00
201.00							201.00
202.00		1,045,060	54,263	1,183,596	448,409	217,196	202.00
203.00		1,427.677596	0.194407	11,835.960000	680.438543	1,497.903448	203.00
204.00		10,272	7,286	13,155	13,282	3,790	204.00
205.00		14.032787	0.026103	131.550000	20.154780	26.137931	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

			Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Disallowance	Total Costs	Inpatient		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS	6,303,368	6,303,368	0	0	2,539,075	30.00	
31.00	03100 INTENSIVE CARE UNIT	1,558,127	1,558,127	0	0	460,030	31.00	
43.00	04300 NURSERY	109,813	109,813	0	0	150,500	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	1,342,929	1,342,929	0	0	547,473	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	164,007	164,007	0	0	116,393	52.00	
53.00	05300 ANESTHESIOLOGY	599,151	599,151	0	0	195,882	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,831,776	2,831,776	0	0	974,947	54.00	
60.00	06000 LABORATORY	3,073,941	3,073,941	0	0	1,129,890	60.00	
65.00	06500 RESPIRATORY THERAPY	870,441	870,441	0	0	407,331	65.00	
66.00	06600 PHYSICAL THERAPY	561,547	561,547	0	0	95,260	66.00	
67.00	06700 OCCUPATIONAL THERAPY	172,746	172,746	0	0	40,572	67.00	
68.00	06800 SPEECH PATHOLOGY	22,337	22,337	0	0	18,289	68.00	
69.00	06900 ELECTROCARDIOLOGY	304,193	304,193	0	0	397,743	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	382,033	382,033	0	0	913,031	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,554	9,554	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,794,801	2,794,801	0	0	1,640,222	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100 EMERGENCY	1,529,091	1,529,091	0	0	142,609	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,255,485	1,255,485	0	0	0	92.00	
200.00	Subtotal (see instructions)	23,885,340	23,885,340	0	0	9,769,247	200.00	
201.00	Less observation Beds	1,255,485	1,255,485	0	0	0	201.00	
202.00	Total (see instructions)	22,629,855	22,629,855	0	0	9,769,247	202.00	
<b>Charges</b>								
Cost Center Description	Outpatient		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	Total (col. 6 + col. 7) 8.00						9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000 ADULTS & PEDIATRICS		2,539,075				30.00	
31.00	03100 INTENSIVE CARE UNIT		460,030				31.00	
43.00	04300 NURSERY		150,500				43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	2,303,351	2,850,824	0.471067	0.000000	0.000000	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	149,707	266,100	0.616336	0.000000	0.000000	52.00	
53.00	05300 ANESTHESIOLOGY	470,565	666,447	0.899023	0.000000	0.000000	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,895,512	13,870,459	0.204159	0.000000	0.000000	54.00	
60.00	06000 LABORATORY	9,637,110	10,767,000	0.285497	0.000000	0.000000	60.00	
65.00	06500 RESPIRATORY THERAPY	191,712	599,043	1.453053	0.000000	0.000000	65.00	
66.00	06600 PHYSICAL THERAPY	1,030,969	1,126,229	0.498608	0.000000	0.000000	66.00	
67.00	06700 OCCUPATIONAL THERAPY	286,927	327,499	0.527470	0.000000	0.000000	67.00	
68.00	06800 SPEECH PATHOLOGY	20,300	38,589	0.578844	0.000000	0.000000	68.00	
69.00	06900 ELECTROCARDIOLOGY	1,477,466	1,875,209	0.162218	0.000000	0.000000	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	909,109	1,822,140	0.209662	0.000000	0.000000	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	61,826	61,826	0.154530	0.000000	0.000000	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	5,400,524	7,040,746	0.396947	0.000000	0.000000	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100 EMERGENCY	4,338,311	4,480,920	0.341245	0.000000	0.000000	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	923,673	923,673	1.359231	0.000000	0.000000	92.00	
200.00	Subtotal (see instructions)	40,097,062	49,866,309				200.00	
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	40,097,062	49,866,309				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

		Title XIX			Hospital		Cost		
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	6,303,368		6,303,368	0	0	2,539,075	30.00
31.00	03100	INTENSIVE CARE UNIT	1,558,127		1,558,127	0	0	460,030	31.00
43.00	04300	NURSERY	109,813		109,813	0	0	150,500	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	1,342,929		1,342,929	0	0	547,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	164,007		164,007	0	0	116,393	52.00
53.00	05300	ANESTHESIOLOGY	599,151		599,151	0	0	195,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,831,776		2,831,776	0	0	974,947	54.00
60.00	06000	LABORATORY	3,073,941		3,073,941	0	0	1,129,890	60.00
65.00	06500	RESPIRATORY THERAPY	870,441	0	870,441	0	0	407,331	65.00
66.00	06600	PHYSICAL THERAPY	561,547	0	561,547	0	0	95,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,746	0	172,746	0	0	40,572	67.00
68.00	06800	SPEECH PATHOLOGY	22,337	0	22,337	0	0	18,289	68.00
69.00	06900	ELECTROCARDIOLOGY	304,193	0	304,193	0	0	397,743	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	382,033		382,033	0	0	913,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,554		9,554	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,794,801		2,794,801	0	0	1,640,222	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	1,529,091		1,529,091	0	0	142,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,255,485		1,255,485	0	0	0	92.00
200.00		Subtotal (see instructions)	23,885,340	0	23,885,340	0	0	9,769,247	200.00
201.00		Less observation Beds	1,255,485		1,255,485	0	0	0	201.00
202.00		Total (see instructions)	22,629,855	0	22,629,855	0	0	9,769,247	202.00
<b>Charges</b>									
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00					9.00	10.00	11.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS		2,539,075					30.00
31.00	03100	INTENSIVE CARE UNIT		460,030					31.00
43.00	04300	NURSERY		150,500					43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	2,303,351	2,850,824	0.471067	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	149,707	266,100	0.616336	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	470,565	666,447	0.899023	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,895,512	13,870,459	0.204159	0.000000	0.000000		54.00
60.00	06000	LABORATORY	9,637,110	10,767,000	0.285497	0.000000	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	191,712	599,043	1.453053	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,030,969	1,126,229	0.498608	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	286,927	327,499	0.527470	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	20,300	38,589	0.578844	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,477,466	1,875,209	0.162218	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	909,109	1,822,140	0.209662	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	61,826	61,826	0.154530	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,400,524	7,040,746	0.396947	0.000000	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	4,338,311	4,480,920	0.341245	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	923,673	923,673	1.359231	0.000000	0.000000		92.00
200.00		Subtotal (see instructions)	40,097,062	49,866,309					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	40,097,062	49,866,309					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part II  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center: Description	Title XVIII			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	52,662	2,850,824	0.018473	194,274	3,589	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	21,938	266,100	0.082443	0	0	52.00
53.00 05300 ANESTHESIOLOGY	1,714	666,447	0.002572	51,102	131	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	49,147	13,870,459	0.003543	755,880	2,678	54.00
60.00 06000 LABORATORY	34,102	10,767,000	0.003167	830,137	2,629	60.00
65.00 06500 RESPIRATORY THERAPY	9,701	599,043	0.016194	222,615	3,605	65.00
66.00 06600 PHYSICAL THERAPY	12,368	1,126,229	0.010982	49,037	539	66.00
67.00 06700 OCCUPATIONAL THERAPY	8,880	327,499	0.027115	21,564	585	67.00
68.00 06800 SPEECH PATHOLOGY	2,116	38,589	0.054834	16,423	901	68.00
69.00 06900 ELECTROCARDIOLOGY	10,011	1,875,209	0.005339	372,632	1,989	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,050	1,822,140	0.004418	60,626	268	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	202	61,826	0.003267	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,651	7,040,746	0.002649	1,486,227	3,937	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	25,273	4,480,920	0.005640	5,220	29	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	923,673	0.000000	0	0	92.00
200.00 Total (lines 50-199)	254,815	46,716,704		4,065,737	20,880	200.00



APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Title XVIII			Hospital		Cost	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part 1, 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	2,850,824	0.000000	0.000000	194,274	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,100	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	666,447	0.000000	0.000000	51,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,870,459	0.000000	0.000000	755,880	54.00
60.00	06000	LABORATORY	0	10,767,000	0.000000	0.000000	830,137	60.00
65.00	06500	RESPIRATORY THERAPY	0	599,043	0.000000	0.000000	222,615	65.00
66.00	06600	PHYSICAL THERAPY	0	1,126,229	0.000000	0.000000	49,037	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327,499	0.000000	0.000000	21,564	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,589	0.000000	0.000000	16,423	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,875,209	0.000000	0.000000	372,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,822,140	0.000000	0.000000	60,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	61,826	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,040,746	0.000000	0.000000	1,486,227	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	4,480,920	0.000000	0.000000	5,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	923,673	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	46,716,704			4,065,737	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Title XVIII			Hospital		Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0	0	0 50.00
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
60.00	06000 LABORATORY	0	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
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: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part V  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Hospital Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.471067	0	1,048,462	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.616336	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.899023	0	110,135	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204159	0	5,085,297	0	0	54.00
60.00	06000 LABORATORY	0.285497	0	4,705,819	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1.453053	0	55,181	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.498608	0	382,685	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.527470	0	95,290	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.578844	0	5,132	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.162218	0	809,685	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209662	0	341,961	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.154530	0	44,964	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.396947	0	2,505,706	502	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0.341245	0	1,475,999	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.359231	0	311,684	0	0	92.00
200.00	Subtotal (see instructions)		0	16,978,000	502	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	16,978,000	502	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part V  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Costs		Hospital	Cost
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	493,896	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	99,014	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,038,209	0		54.00
60.00	06000 LABORATORY	1,343,497	0		60.00
65.00	06500 RESPIRATORY THERAPY	80,181	0		65.00
66.00	06600 PHYSICAL THERAPY	190,810	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	50,263	0		67.00
68.00	06800 SPEECH PATHOLOGY	2,971	0		68.00
69.00	06900 ELECTROCARDIOLOGY	131,345	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	71,696	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,948	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	994,632	199		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	503,677	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	423,651	0		92.00
200.00	Subtotal (see instructions)	5,430,790	199		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 +/- line 201)	5,430,790	199		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

Period: From 01/01/2012

Worksheet D

Component CCN: 152317

To 12/31/2012

Part V  
Date/Time Prepared: 5/30/2013 10:22 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Reimbursed Services (see inst.)	PPS Services (see inst.)
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000 OPERATING ROOM	0.471067	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.616336	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.899023	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204159	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0.285497	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1.453053	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.498608	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.527470	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.578844	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.162218	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209662	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.154530	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.396947	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100 EMERGENCY	0.341245	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.359231	0	0	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	0	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	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D  
Part V  
Date/Time Prepared:  
5/30/2013 10:22 am

Component CCN: 152317

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	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)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-1

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Title XVIII	Hospital	Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,279	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,013	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)		2,361	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		260	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		6	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)		1,718	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)		260	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		152.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,303,368	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)		915	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)		501,568	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,801,800	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,624,340	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,624,340	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.210765	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)		1,111.54	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)		5,801,800	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)		1,925.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,308,164	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)		3,308,164	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-1

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Title XVIII			Hospital	Cost	
	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
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	1,558,127	228	6,833.89	199	1,359,944	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
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,562,474	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,230,582	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					500,653	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)					500,653	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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					652	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,925.59	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,255,485	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-1

Date/Time Prepared:  
5/30/2013 10:22 am

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-1

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Title XIX	Hospital	Cost	
				1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>					
<b>INPATIENT DAYS</b>					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,279	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,013	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)			2,361	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			260	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			6	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)			64	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)			140	15.00
16.00	Nursery days (title V or XIX only)			73	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				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			6,303,368	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)			500,726	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,802,642	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>					
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,624,340	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,624,340	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			2.211086	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)			1,111.54	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)			5,802,642	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)			1,925.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			123,256	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)			123,256	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-1

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Title XIX			Hospital		Cost	
	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)	109,813	140	784.38	73	57,260		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	1,558,127	228	6,833.89	3	20,502		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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					216,844		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					417,862		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					652		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,925.87		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,255,667		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-1

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description	Cost	Title XIX		Hospital	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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
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: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-3

Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Title XVIII	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		1,855,600	30.00
31.00	03100 INTENSIVE CARE UNIT		356,210	31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.471067	194,274	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.616336	0	52.00
53.00	05300 ANESTHESIOLOGY	0.899023	51,102	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204159	755,880	54.00
60.00	06000 LABORATORY	0.285497	830,137	60.00
65.00	06500 RESPIRATORY THERAPY	1.453053	222,615	65.00
66.00	06600 PHYSICAL THERAPY	0.498608	49,037	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.527470	21,564	67.00
68.00	06800 SPEECH PATHOLOGY	0.578844	16,423	68.00
69.00	06900 ELECTROCARDIOLOGY	0.162218	372,632	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209662	60,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.154530	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.396947	1,486,227	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.341245	5,220	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.359231	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,065,737	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)		4,065,737	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151317	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3
	Component CCN: 152317		Date/Time Prepared: 5/30/2013 10:22 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<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	0.471067	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.616336	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.899023	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204159	19,331	3,947	54.00
60.00	06000 LABORATORY	0.285497	42,984	12,272	60.00
65.00	06500 RESPIRATORY THERAPY	1.453053	25,828	37,529	65.00
66.00	06600 PHYSICAL THERAPY	0.498608	27,931	13,927	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.527470	16,173	8,531	67.00
68.00	06800 SPEECH PATHOLOGY	0.578844	467	270	68.00
69.00	06900 ELECTROCARDIOLOGY	0.162218	15,341	2,489	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209662	35,878	7,522	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.154530	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.396947	39,443	15,657	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.341245	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.359231	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		223,376	102,144	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)		223,376		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet D-3

Date/Time Prepared:  
5/30/2013 10:22 am

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		197,171	30.00
31.00	03100 INTENSIVE CARE UNIT		8,950	31.00
43.00	04300 NURSERY		91,375	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.471067	159,586	75,176 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.616336	35,951	22,158 52.00
53.00	05300 ANESTHESIOLOGY	0.899023	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.204159	36,435	7,439 54.00
60.00	06000 LABORATORY	0.285497	123,208	35,176 60.00
65.00	06500 RESPIRATORY THERAPY	1.453053	10,705	15,555 65.00
66.00	06600 PHYSICAL THERAPY	0.498608	1,433	715 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.527470	588	310 67.00
68.00	06800 SPEECH PATHOLOGY	0.578844	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.162218	9,770	1,585 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.209662	46,077	9,661 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.154530	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.396947	114,552	45,471 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.341245	10,544	3,598 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.359231	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		548,849	216,844 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		548,849	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet E  
Part B  
Date/Time Prepared:  
5/30/2013 10:22 am

		Title XVIII	Hospital	Cost	
				1.00	
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>					
1.00	Medical and other services (see instructions)			5,430,989	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	PPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,430,989	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)			5,485,299	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)			0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
25.00	Deductibles and coinsurance (for CAH, see instructions)			33,991	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,462,735	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)			2,988,573	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)			2,988,573	30.00
31.00	Primary payer payments			339	31.00
32.00	Subtotal (line 30 minus line 31)			2,988,234	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)			385,429	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			385,429	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			385,429	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,373,663	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.98	AB Re-billing demo amount (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,373,663	40.00
41.00	Interim payments			3,927,125	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)			-553,462	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			99,664	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
				<b>Overrides</b>	
				1.00	
<b>WORKSHEET OVERRIDE VALUES</b>					
112.00	override of Ancillary service charges (line 12)			0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 10:22 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
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		5,359,582		3,927,125		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
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	08/17/2012	58,600			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
<b>Provider to Program</b>							
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)		58,600			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)		5,418,182		3,927,125		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
<b>Provider to Program</b>							
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		471,138			0	6.01
6.02	SETTLEMENT TO PROGRAM		0		553,462		6.02
7.00	Total Medicare program liability (see instructions)		5,889,320		3,373,663		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: 151317

Period: From 01/01/2012 To 12/31/2012

Worksheet E-1 Part I

Component CCN: 152317

Date/Time Prepared: 5/30/2013 10:22 am

		Title XVIII		Swing Beds - SNF		Cost	
		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		552,381		0	1.00	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	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	3.00
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	3.01
3.02			0		0	3.02	3.02
3.03			0		0	3.03	3.03
3.04			0		0	3.04	3.04
3.05			0		0	3.05	3.05
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	3.50
3.51			0		0	3.51	3.51
3.52			0		0	3.52	3.52
3.53			0		0	3.53	3.53
3.54			0		0	3.54	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	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)		552,381		0	4.00	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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	5.00
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	5.01
5.02			0		0	5.02	5.02
5.03			0		0	5.03	5.03
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	5.50
5.51			0		0	5.51	5.51
5.52			0		0	5.52	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	6.00
6.01	SETTLEMENT TO PROVIDER		48,641		0	6.01	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	6.02
7.00	Total Medicare program liability (see instructions)		601,022		0	7.00	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: 151317	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/30/2013 10:22 am
		Title XVIII	Hospital	Cost
				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		809	1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12		1,917	2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2		0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		2,589	4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200		49,866,309	5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20		1,045,308	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)		0	32.00
				<b>Overrides</b>
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment		0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151317	Period: From 01/01/2012 To 12/31/2012	Worksheet E-2
	Component CCN: 152317		Date/Time Prepared: 5/30/2013 10:22 am

		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	505,660	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	103,165	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	260	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	608,825	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	608,825	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	608,825	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,803	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	601,022	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	601,022	0	19.00
20.00	Interim payments	552,381	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	48,641	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	12,843	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet E-3  
Part V  
Date/Time Prepared:  
5/30/2013 10:22 am

	Title XVIII	Hospital	Cost	
			1.00	
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		6,230,582	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		6,230,582	4.00
5.00	Primary payer payments		875	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		6,292,013	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		6,292,013	19.00
20.00	Deductibles (exclude professional component)		434,862	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		5,857,151	22.00
23.00	Coinsurance		2,312	23.00
24.00	Subtotal (line 22 minus line 23)		5,854,839	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		34,481	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		34,481	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,481	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,889,320	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		5,889,320	30.00
31.00	Interim payments		5,418,182	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		471,138	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		130,499	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet E-3  
Part VII  
Date/Time Prepared:  
5/30/2013 10:22 am

	Title XIX	Hospital		
		Cost		
		Inpatient	Outpatient	
		1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	417,862		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	417,862	0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	417,862	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	297,496		8.00
9.00	Ancillary service charges	548,849	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	846,345	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	846,345	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	428,483	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	417,862	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	417,862	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	417,862	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	417,862	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	417,862	0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	417,862	0	40.00
41.00	Interim payments	417,862	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet G

Date/Time Prepared:  
5/30/2013 10:22 am

	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	2,282,245	0	0	0	1.00
2.00 Temporary investments	2,034,108	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	16,061,612	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	296,356	0	0	0	7.00
8.00 Prepaid expenses	74,792	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	8,329,704	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	29,078,817	0	0	0	11.00
<b>FIXED ASSETS</b>					
12.00 Land	759,198	0	0	0	12.00
13.00 Land improvements	425,781	0	0	0	13.00
14.00 Accumulated depreciation	-397,736	0	0	0	14.00
15.00 Buildings	7,173,272	0	0	0	15.00
16.00 Accumulated depreciation	-5,899,932	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	1,144,420	0	0	0	19.00
20.00 Accumulated depreciation	-825,895	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	3,608,549	0	0	0	23.00
24.00 Accumulated depreciation	-2,838,023	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	3,149,634	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	458,280	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	458,280	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	32,686,731	0	0	0	36.00
<b>CURRENT LIABILITIES</b>					
37.00 Accounts payable	216,279	0	0	0	37.00
38.00 Salaries, wages, and fees payable	955,778	0	0	0	38.00
39.00 Payroll taxes payable	159,744	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	0	0	0	0	43.00
44.00 Other current liabilities	4,431,420	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	5,763,221	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)	5,763,221	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>					
52.00 General fund balance	26,923,510	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	26,923,510	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	32,686,731	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet G-1

Date/Time Prepared:  
5/30/2013 10:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
		1.00	Fund balances at beginning of period		25,983,780		
2.00	Net income (loss) (from wkst. G-3, line 29)		982,431				2.00
3.00	Total (sum of line 1 and line 2)		26,966,211		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,966,211		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN PRIOR YEAR RE	42,701		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		42,701		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,923,510		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	CHANGE IN PRIOR YEAR RE		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2013 10:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	2,624,340		2,624,340	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,624,340		2,624,340	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	460,030		460,030	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)	460,030		460,030	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,084,370		3,084,370	17.00
18.00	Ancillary services	6,580,140	43,885,668	50,465,808	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	9,664,510	43,885,668	53,550,178	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		23,661,294		29.00
30.00	BAD DEBT	4,511,856			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)		4,511,856		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)		28,173,150		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151317

Period:  
From 01/01/2012  
To 12/31/2012

Worksheet G-3

Date/Time Prepared:  
5/30/2013 10:22 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	53,550,178	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,416,923	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,133,255	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	28,173,150	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-39,895	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	90	6.00
7.00	Income from investments	36,184	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	258,770	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	6,634	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	44,734	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	23,639	24.00
24.01	MISC INCOME	356,516	24.01
24.02	DSH PAYMENT	294,781	24.02
24.03	CPR TRAINING	978	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	1,022,326	25.00
26.00	Total (line 5 plus line 25)	982,431	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	982,431	29.00