

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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	FORM APPROVED OMB NO. 0938-0050 Worksheet S Parts I-III Date/Time Prepared: 1/30/2013 4:44 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/30/2013 Time: 4:44 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

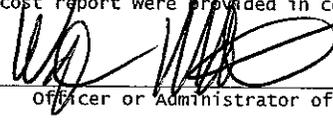
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by UNION HOSPITAL CLINTON (151326) for the cost reporting period beginning 09/01/2011 and ending 08/31/2012 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: 1/30/2013 Time: 4:44 pm
 QRcAfpDDTsnnGpPevHkwIKWHSwwd.0
 n8c0q0bJkPPRM7Mc7vUSGjJa0i.4K2
 aC0Q0YR9fs0:cIXH
 PI: Date: 1/30/2013 Time: 4:44 pm
 o8.iI:B0LKoFF9vYy3wqTTkwfw6FL0
 Fe91Z0fsJRRNR2I9.zzi1g055cFO0uU
 shFNHQ3zyC0Jtwig

(Signed)


 Officer or Administrator of Provider(s)
 Executive Vice President/CFO

Title

January 31, 2013

Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	361,310	-1,678,139	0	-75,972	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	17,352	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	378,662	-1,678,139	0	-75,972	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: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-2
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

	1.00	2.00	3.00	4.00								
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 801 SOUTH MAIN STREET		PO Box:								1.00	
2.00	City: CLINTON		State: IN		Zip Code: 47842-		County: VERMILLION				2.00	
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)						
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	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	SWING BEDS	152326	45460		03/01/2005	N	O	O			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)					09/01/2011		08/31/2012				20.00
21.00	Type of Control (see instructions)							2				21.00
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N				22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					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		25.00
		Urban/Rural S	Date of Geogr									
		1.00	2.00									
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2						26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2						27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0						35.00
						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

		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N			58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME 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)		0.00	0.00	61.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01		
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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	<p>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</p> <p>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)</p>	0.00	0.00	0.000000	66.00
		1.00	2.00	3.00	
67.00	<p>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.</p>	0.00	0.00	0.000000	67.00
		1.00	2.00	3.00	
		4.00	5.00		
		1.00	2.00	3.00	
70.00	<p>Inpatient Psychiatric Facility PPS</p> <p>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</p>		N		70.00
71.00	<p>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)</p>			0	71.00
75.00	<p>Inpatient Rehabilitation Facility PPS</p> <p>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</p>		N		75.00
76.00	<p>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)</p>			0	76.00
				1.00	
80.00	<p>Long Term Care Hospital PPS</p> <p>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</p>		N		80.00
85.00	<p>TEFRA Providers</p> <p>Is this a new hospital under 42 CFR section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</p>		N		85.00
86.00	<p>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.</p>		N		86.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:151326	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 4:42 pm	
		V 1.00	XIX 2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	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.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00 3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	62,517	0	0	
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
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
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
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.				
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.				
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.				
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.				
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.				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 4:42 pm			
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.	1.00	2.00		131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00		
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H043		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: UNION HOSPITAL, INC.	Contractor's Name: N/A		Contractor's Number: N/A			
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:					
143.00	City: TERRE HAUTE	State: IN	Zip Code: 47804				
144.00	Are provider based physicians' costs included in worksheet A?		Y	1.00	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	1.00	145.00		
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		1.00	146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		1.00	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		1.00	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		1.00	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		
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	1.00		
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	Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
							0.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			Y	1.00	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0.00	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/30/2013 4:42 pm
		Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/16/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

	Description	Part A		
		Y/N	Date	
	0	1.00	2.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y		25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	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	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHANTHA	AARON	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNION HOSPITAL, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-238-7655	FASSA@UHHG.ORG	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/16/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONTROLLER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	19	6,954	53,208.00		1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		19	6,954	53,208.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	11,592.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	64,800.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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						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

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,308	261	2,217	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF Subprovider		0	0		3.00	
4.00 HMO IRF Subprovider		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	146	0	174	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,454	261	2,391	7.00	
8.00 INTENSIVE CARE UNIT	0	256	0	493	8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY					13.00	
14.00 Total (see instructions)	0	1,710	261	2,884	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					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)					27.00	
28.00 Observation Bed Days	0		122	944	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges			
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII		
	9.00	10.00	11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	588	1.00	
2.00 HMO					0	2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00	
6.00 Hospital Adults & Peds. Swing Bed NF						6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)	0.00	159.66	0.00	0	588	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)	0.00	159.66	0.00			27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
33.00 LTCH non-covered days						33.00	

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	103	1,344	1.00
2.00 HMO			2.00
3.00 HMO IPF Subprovider			3.00
4.00 HMO IRF Subprovider			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF			5.00
6.00 Hospital Adults & Peds. Swing Bed NF			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)			7.00
8.00 INTENSIVE CARE UNIT			8.00
9.00 CORONARY CARE UNIT			9.00
10.00 BURN INTENSIVE CARE UNIT			10.00
11.00 SURGICAL INTENSIVE CARE UNIT			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)			12.00
13.00 NURSERY			13.00
14.00 Total (see instructions)	103	1,344	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.293705	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			3,798,333	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			11,792,456	6.00
7.00	Medicaid cost (line 1 times line 6)			3,463,503	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			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
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,576,037	0	3,576,037	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,050,300	0	1,050,300	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,050,300	0	1,050,300	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,514,863	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			680,613	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			3,834,250	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			1,126,138	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			2,176,438	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,176,438	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A

Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		564,048		564,048	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		428,822		428,822	2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.01	00510	NONPATIENT TELEPHONES	0	19,792		19,792	5.01
5.02	00511	DATA PROCESSING	0	274,026		274,026	5.02
5.03	00512	PURCHASING RECEIVING AND STORES	0	328		328	5.03
5.04	00513	ADMITTING	296,905	127,215		424,120	5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	21,307	424,693		446,000	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	534,573	448,360		982,933	5.06
7.00	00700	OPERATION OF PLANT	378,562	562,111		940,673	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,809		2,809	8.00
9.00	00900	HOUSEKEEPING	240,590	77,145		317,735	9.00
10.00	01000	DIETARY	319,305	235,011		554,316	10.00
11.00	01100	CAFETERIA	0	0	-283,726	270,590	11.00
13.00	01300	NURSING ADMINISTRATION	520,741	115,320	283,726	283,726	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,130	74,833		269,963	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,248,319	503,884		1,752,203	30.00
31.00	03100	INTENSIVE CARE UNIT	675,982	108,644		784,626	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	360,702	921,126		1,281,828	50.00
51.00	05100	RECOVERY ROOM	70,353	6,655		77,008	51.00
51.01	05101	O/P TREATMENT ROOM	148,700	28,823		177,523	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,944	914,788		2,277,732	54.00
56.00	05600	RADIOISOTOPE	0	143,284		143,284	56.00
60.00	06000	LABORATORY	0	1,189,767		1,189,767	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	81,244		81,244	62.00
65.00	06500	RESPIRATORY THERAPY	298,690	107,147		405,837	65.00
66.00	06600	PHYSICAL THERAPY	265,115	52,204		317,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,889	19,150		140,039	67.00
68.00	06800	SPEECH PATHOLOGY	18,169	6,704		24,873	68.00
69.00	06900	ELECTROCARDIOLOGY	109,784	67,005		176,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,519		97,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,186	25,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	398,612	790,427		1,189,039	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,202	1,553		10,755	90.00
91.00	09100	EMERGENCY	1,245,828	502,092		1,747,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,840,402	8,896,529		17,736,931	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	365,604	123,604		489,208	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	9,206,006	9,020,133		18,226,139	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A

Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	170,794	734,842	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	814,247	1,243,069	2.00
4.00	00400 EMPLOYEE BENEFITS	1,349,692	1,349,692	4.00
5.01	00510 NONPATIENT TELEPHONES	41,425	61,217	5.01
5.02	00511 DATA PROCESSING	1,355,749	1,629,775	5.02
5.03	00512 PURCHASING RECEIVING AND STORES	111,871	112,199	5.03
5.04	00513 ADMITTING	0	424,120	5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE	498,494	944,494	5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	925,878	1,908,811	5.06
7.00	00700 OPERATION OF PLANT	75,817	1,016,490	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	2,809	8.00
9.00	00900 HOUSEKEEPING	55,100	372,835	9.00
10.00	01000 DIETARY	4,392	274,982	10.00
11.00	01100 CAFETERIA	-159,833	123,893	11.00
13.00	01300 NURSING ADMINISTRATION	67,598	703,659	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,994	271,957	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-234,757	1,517,446	30.00
31.00	03100 INTENSIVE CARE UNIT	0	784,626	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-495,014	761,628	50.00
51.00	05100 RECOVERY ROOM	332	77,340	51.00
51.01	05101 O/P TREATMENT ROOM	0	177,523	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	-515,813	1,761,919	54.00
56.00	05600 RADIOISOTOPE	0	143,284	56.00
60.00	06000 LABORATORY	-173,165	1,016,602	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	81,244	62.00
65.00	06500 RESPIRATORY THERAPY	0	405,837	65.00
66.00	06600 PHYSICAL THERAPY	27,334	344,653	66.00
67.00	06700 OCCUPATIONAL THERAPY	9,497	149,536	67.00
68.00	06800 SPEECH PATHOLOGY	1,759	26,632	68.00
69.00	06900 ELECTROCARDIOLOGY	-129,294	47,495	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-36	97,483	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	25,186	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33,290	1,222,329	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	10,755	90.00
91.00	09100 EMERGENCY	-189,900	1,558,020	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,647,451	21,384,382	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950 PHYSICIAN PRACTICES	0	489,208	194.00
194.01	07951 MEDICAL OFFICE BUILDING	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	3,647,451	21,873,590	200.00

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-6

Date/Time Prepared:
1/30/2013 4:42 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY				
1.00	CAFETERIA	11.00	102,420	181,306	1.00
	TOTALS		102,420	181,306	
	B - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO	72.00	0	25,186	1.00
	PATIENTS				
	TOTALS		0	25,186	
500.00	Grand Total: Increases		102,420	206,492	500.00

RECLASSIFICATIONS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-6

Date/Time Prepared:
1/30/2013 4:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - DIETARY							
1.00	DIETARY	10.00	102,420	181,306	0		1.00
	TOTALS		102,420	181,306			
B - IMPLANTS							
1.00	OPERATING ROOM	50.00	0	25,186	0		1.00
	TOTALS		0	25,186			
500.00	Grand Total: Decreases		102,420	206,492			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2013 4:42 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	282,637	0	0	0	1.00
2.00	Land Improvements	186,379	27,305	0	27,305	2.00
3.00	Buildings and Fixtures	5,699,016	0	0	0	3.00
4.00	Building Improvements	3,312,875	1,317,955	0	1,317,955	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	4,844,388	539,749	0	539,749	43,571
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,325,295	1,885,009	0	1,885,009	43,571
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,325,295	1,885,009	0	1,885,009	43,571
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	564,048	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	428,822	0	0	0	2.00
3.00	Total (sum of lines 1-2)	992,870	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,826,168	0	10,826,168	0.669657	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,340,565	0	5,340,565	0.330343	2.00
3.00	Total (sum of lines 1-2)	16,166,733	0	16,166,733	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2013 4:42 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	282,637	0			1.00
2.00	Land Improvements	213,684	0			2.00
3.00	Buildings and Fixtures	5,699,016	0			3.00
4.00	Building Improvements	4,630,830	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,340,566	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	16,166,733	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	16,166,733	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	564,048			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	428,822			2.00
3.00	Total (sum of lines 1-2)	0	992,870			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	734,842	0 1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,243,069	0 2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,977,911	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	15.00		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	734,842	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,243,069	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,977,911	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-8

Date/Time Prepared:
1/30/2013 4:42 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted	
				Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00
3.00	Investment income - other (chapter 2)			0	
4.00	Trade, quantity, and time discounts (chapter 8)	B	-38		PURCHASING RECEIVING AND STORES 5.03 4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	
6.00	Rental of provider space by suppliers (chapter 8)			0	
7.00	Telephone services (pay stations excluded) (chapter 21)			0	
8.00	Television and radio service (chapter 21)			0	
9.00	Parking lot (chapter 21)			0	
10.00	Provider-based physician adjustment	A-8-2	-1,202,850		
11.00	Sale of scrap, waste, etc. (chapter 23)			0	
12.00	Related organization transactions (chapter 10)	A-8-1	5,680,896		
13.00	Laundry and linen service			0	
14.00	Cafeteria-employees and guests	B	-172,678	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others			0	
16.00	Sale of medical and surgical supplies to other than patients			0	
17.00	Sale of drugs to other than patients			0	
18.00	Sale of medical records and abstracts	B	-9,607	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)			0	
20.00	Vending machines			0	
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	
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 26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP 2.00 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted *** 19.00 28.00
29.00	Physicians' assistant			0	
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	
33.00	ADVERTISING	A	-17,072	OTHER ADMINISTRATIVE AND GENERAL	5.06 33.00
34.00	CRNA	A	-505,772	OPERATING ROOM	50.00 34.00
35.00	RENTAL REVENUE	B	-124,648	OPERATION OF PLANT	7.00 35.00
36.00	LOBBYING COSTS	A	-510	OTHER ADMINISTRATIVE AND GENERAL	5.06 36.00
37.00	CATERING	B	-1,981	CAFETERIA	11.00 37.00
38.00	VPCHC	A	4,981	OTHER ADMINISTRATIVE AND GENERAL	5.06 38.00
39.00	MISCELLANEOUS	B	-1,882	OTHER ADMINISTRATIVE AND GENERAL	5.06 39.00
40.00	MISCELLANEOUS	B	-10	NEW CAP REL COSTS-MVBLE EQUIP	2.00 40.00
41.00	MISCELLANEOUS	B	-75	NURSING ADMINISTRATION	13.00 41.00
42.00	MISCELLANEOUS	B	-4,850	RADIOLOGY-DIAGNOSTIC	54.00 42.00
43.00	MISCELLANEOUS	B	-36	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 43.00
44.00	MISCELLANEOUS	B	-600	NONPATIENT TELEPHONES	5.01 44.00
45.00	MISCELLANEOUS	B	-1,802	DRUGS CHARGED TO PATIENTS	73.00 45.00

Provider CCN: 151326

Period:
 From 09/01/2011
 To 08/31/2012

Worksheet A-8

Date/Time Prepared:
 1/30/2013 4:42 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		
			Cost Center	Line #	
	1.00	-2.00	3.00	4.00	
46.00 MISCELLANEOUS	B	-34	CASHIERING/ACCOUNTS RECEIVABLE	5.05	46.00
47.00 INSURANCE FROM UHTH	A	6,019	OTHER ADMINISTRATIVE AND GENERAL	5.06	47.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		3,647,451			50.00

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00 Non-physician Anesthetist		28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00 ADVERTISING	0	33.00
34.00 CRNA	0	34.00
35.00 RENTAL REVENUE	0	35.00
36.00 LOBBYING COSTS	0	36.00
37.00 CATERING	0	37.00
38.00 VPCHC	0	38.00
39.00 MISCELLANEOUS	0	39.00
40.00 MISCELLANEOUS	9	40.00
41.00 MISCELLANEOUS	0	41.00
42.00 MISCELLANEOUS	0	42.00
43.00 MISCELLANEOUS	0	43.00
44.00 MISCELLANEOUS	0	44.00
45.00 MISCELLANEOUS	0	45.00
46.00 MISCELLANEOUS	0	46.00
47.00 INSURANCE FROM UHTH	0	47.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	60.00	LABORATORY	LAB	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	HOME OFFICE	2.00
3.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3.00
4.00	9.00	HOUSEKEEPING	HOME OFFICE	4.00
4.01	5.01	NONPATIENT TELEPHONES	HOME OFFICE	4.01
4.02	50.00	OPERATING ROOM	HOME OFFICE	4.02
4.03	51.00	RECOVERY ROOM	HOME OFFICE	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	4.04
4.05	66.00	PHYSICAL THERAPY	HOME OFFICE	4.05
4.06	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	4.06
4.07	68.00	SPEECH PATHOLOGY	HOME OFFICE	4.07
4.08	69.00	ELECTROCARDIOLOGY	HOME OFFICE	4.08
4.09	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	4.09
4.10	7.00	OPERATION OF PLANT	HOME OFFICE	4.10
4.11	10.00	DIETARY	HOME OFFICE	4.11
4.12	11.00	CAFETERIA	HOME OFFICE	4.12
4.13	5.03	PURCHASING RECEIVING AND STORES	HOME OFFICE	4.13
4.14	5.02	DATA PROCESSING	HOME OFFICE	4.14
4.15	13.00	NURSING ADMINISTRATION	HOME OFFICE	4.15
4.16	4.00	EMPLOYEE BENEFITS	HOME OFFICE	4.16
4.17	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	4.17
4.18	5.05	CASHIERING/ACCOUNTS RECEIVABLE	HOME OFFICE	4.18
4.19	5.06	OTHER ADMINISTRATIVE AND GENERAL	HOME OFFICE	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00		G		0.00	6.00
7.00		G		0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER			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: 151326

Period: From 09/01/2011 To 08/31/2012

Worksheet A-8-1

Date/Time Prepared: 1/30/2013 4:42 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	1,016,602	1,189,767	-173,165	0	1.00
2.00	170,794	0	170,794	9	2.00
3.00	814,257	0	814,257	9	3.00
4.00	55,100	0	55,100	0	4.00
4.01	42,025	0	42,025	0	4.01
4.02	10,758	0	10,758	0	4.02
4.03	332	0	332	0	4.03
4.04	132,085	0	132,085	0	4.04
4.05	27,334	0	27,334	0	4.05
4.06	9,497	0	9,497	0	4.06
4.07	1,759	0	1,759	0	4.07
4.08	5,851	0	5,851	0	4.08
4.09	35,092	0	35,092	0	4.09
4.10	200,465	0	200,465	0	4.10
4.11	4,392	0	4,392	0	4.11
4.12	14,826	0	14,826	0	4.12
4.13	111,909	0	111,909	0	4.13
4.14	1,355,749	0	1,355,749	0	4.14
4.15	67,673	0	67,673	0	4.15
4.16	1,349,692	0	1,349,692	0	4.16
4.17	11,601	0	11,601	0	4.17
4.18	498,528	0	498,528	0	4.18
4.19	934,342	0	934,342	0	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	6,870,663	1,189,767	5,680,896	5.00

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

Related Organization(s) and/or Home Office		
Name	Percentage of Ownership	Type of Business
4.00	5.00	6.00

B. 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	TH MEDICAL LAB	0.00	LAB	6.00
7.00	UNION HOSPITAL	0.00	HOME OFFICE	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 4:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	ADULTS & PEDIATRICS	260,840	234,757	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	643,048	643,048	2.00
3.00	91.00	EMERGENCY	189,900	189,900	3.00
4.00	69.00	ELECTROCARDIOLOGY	135,145	135,145	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,228,933	1,202,850	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 4:42 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	26,083	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	26,083					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 4:42 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:
1/30/2013 4:42 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	234,757	1.00
2.00	0	643,048	2.00
3.00	0	189,900	3.00
4.00	0	135,145	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,202,850	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	NONPATIENT TELEPHONES	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	734,842	734,842			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,243,069		1,243,069		2.00
4.00 00400	EMPLOYEE BENEFITS	1,349,692	0	0	1,349,692	4.00
5.01 00510	NONPATIENT TELEPHONES	61,217	926	61,226	0	123,369 5.01
5.02 00511	DATA PROCESSING	1,629,775	2,705	370,022	0	1,756 5.02
5.03 00512	PURCHASING RECEIVING AND STORES	112,199	5,286	994	0	878 5.03
5.04 00513	ADMITTING	424,120	3,364	110	43,529	2,634 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	944,494	2,652	0	3,124	2,634 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	1,908,811	11,685	54,789	78,374	6,146 5.06
7.00 00700	OPERATION OF PLANT	1,016,490	192,525	31,777	55,501	11,415 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,809	2,768	1,433	0	0 8.00
9.00 00900	HOUSEKEEPING	372,835	3,489	8,695	35,273	439 9.00
10.00 01000	DIETARY	274,982	29,822	46,148	31,798	3,073 10.00
11.00 01100	CAFETERIA	123,893	0	0	15,016	0 11.00
13.00 01300	NURSING ADMINISTRATION	703,659	9,229	22,132	76,346	1,756 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	271,957	7,787	998	28,608	3,951 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,517,446	124,483	46,959	183,016	30,736 30.00
31.00 03100	INTENSIVE CARE UNIT	784,626	3,649	158,454	99,106	3,512 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	761,628	19,943	139,621	52,883	3,073 50.00
51.00 05100	RECOVERY ROOM	77,340	2,679	5,317	10,314	878 51.00
51.01 05101	O/P TREATMENT ROOM	177,523	14,310	11,745	21,801	2,195 51.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,761,919	39,050	89,707	199,818	6,586 54.00
56.00 05600	RADIOISOTOPE	143,284	2,341	0	0	439 56.00
60.00 06000	LABORATORY	1,016,602	15,227	0	0	2,195 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	81,244	0	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	405,837	4,040	27,066	43,791	2,634 65.00
66.00 06600	PHYSICAL THERAPY	344,653	30,071	51,957	38,869	5,268 66.00
67.00 06700	OCCUPATIONAL THERAPY	149,536	25,292	862	17,724	3,512 67.00
68.00 06800	SPEECH PATHOLOGY	26,632	3,417	0	2,664	439 68.00
69.00 06900	ELECTROCARDIOLOGY	47,495	3,186	20,929	16,095	1,756 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,483	9,042	0	0	439 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	25,186	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,222,329	9,024	2,759	58,441	2,195 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	10,755	712	0	1,349	439 90.00
91.00 09100	EMERGENCY	1,558,020	56,181	88,116	182,651	12,732 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,384,382	634,885	1,241,816	1,296,091	113,710 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	PHYSICIAN PRACTICES	489,208	19,329	1,253	53,601	9,659 194.00
194.01 07951	MEDICAL OFFICE BUILDING	0	80,628	0	0	0 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	21,873,590	734,842	1,243,069	1,349,692	123,369 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS							
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
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING	2,004,258				5.02
5.03	00512	PURCHASING RECEIVING AND STORES	13,542	132,899			5.03
5.04	00513	ADMITTING	81,254	220	555,231		5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	27,085	0	0	979,989	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	189,592	44	0	0	2,249,441
7.00	00700	OPERATION OF PLANT	365,641	17	0	0	1,673,366
8.00	00800	LAUNDRY & LINEN SERVICE	0	783	0	0	7,793
9.00	00900	HOUSEKEEPING	13,542	7,209	0	0	441,482
10.00	01000	DIETARY	40,627	10	0	0	426,460
11.00	01100	CAFETERIA	0	0	0	0	138,909
13.00	01300	NURSING ADMINISTRATION	54,169	5	0	0	867,296
16.00	01600	MEDICAL RECORDS & LIBRARY	108,338	29	0	0	421,668
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	108,338	21,213	25,367	44,774	2,102,332
31.00	03100	INTENSIVE CARE UNIT	13,542	8,377	10,035	17,712	1,099,013
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	54,169	53,230	46,922	82,821	1,214,290
51.00	05100	RECOVERY ROOM	0	5	1,540	2,719	100,792
51.01	05101	O/P TREATMENT ROOM	13,542	3,446	8,997	15,880	269,439
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,881	9,884	155,912	275,161	2,659,918
56.00	05600	RADIOISOTOPE	0	128	6,033	10,649	162,874
60.00	06000	LABORATORY	13,542	0	77,981	137,643	1,263,190
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	602	1,063	82,909
65.00	06500	RESPIRATORY THERAPY	27,085	3,128	6,879	12,143	532,603
66.00	06600	PHYSICAL THERAPY	135,423	350	11,310	19,963	637,864
67.00	06700	OCCUPATIONAL THERAPY	0	1	3,927	6,931	207,785
68.00	06800	SPEECH PATHOLOGY	0	0	728	1,284	35,164
69.00	06900	ELECTROCARDIOLOGY	0	117	18,482	32,622	140,682
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37	1,026	1,811	109,838
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	252	445	25,883
73.00	07300	DRUGS CHARGED TO PATIENTS	40,627	588	58,676	103,568	1,498,207
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	112	198	13,565
91.00	09100	EMERGENCY	216,677	23,541	115,878	204,532	2,458,328
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,638,616	132,362	550,659	971,919	20,841,091
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	365,642	537	4,572	8,070	951,871
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	80,628
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,004,258	132,899	555,231	979,989	21,873,590

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
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
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING RECEIVING AND STORES					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	2,249,441				5.06
7.00	00700	OPERATION OF PLANT	191,811	1,865,177			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	893	10,010	18,696		8.00
9.00	00900	HOUSEKEEPING	50,605	12,617	0	504,704	9.00
10.00	01000	DIETARY	48,883	107,859	0	29,544	612,746
11.00	01100	CAFETERIA	15,923	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,415	33,378	0	9,143	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,334	28,164	0	7,714	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	240,982	450,233	5,740	123,325	499,067
31.00	03100	INTENSIVE CARE UNIT	125,975	13,197	1,891	3,615	102,870
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	139,189	72,131	1,262	19,758	0
51.00	05100	RECOVERY ROOM	11,553	9,688	0	2,654	0
51.01	05101	O/P TREATMENT ROOM	30,885	51,757	0	14,177	10,809
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,900	141,237	1,663	38,687	0
56.00	05600	RADIOISOTOPE	18,670	8,465	0	2,319	0
60.00	06000	LABORATORY	144,794	55,072	0	15,085	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,504	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	61,050	14,613	0	4,003	0
66.00	06600	PHYSICAL THERAPY	73,116	108,760	1,424	29,791	0
67.00	06700	OCCUPATIONAL THERAPY	23,818	91,476	0	25,057	0
68.00	06800	SPEECH PATHOLOGY	4,031	12,360	0	3,386	0
69.00	06900	ELECTROCARDIOLOGY	16,126	11,523	244	3,156	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,590	32,702	0	8,958	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,967	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	171,733	32,638	0	8,940	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,555	2,575	0	705	0
91.00	09100	EMERGENCY	281,788	203,197	6,472	55,659	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,131,090	1,503,652	18,696	405,676	612,746
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	109,109	69,910	0	19,150	0
194.01	07951	MEDICAL OFFICE BUILDING	9,242	291,615	0	79,878	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,249,441	1,865,177	18,696	504,704	612,746

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	154,832					11.00
13.00	01300	8,844	1,018,076				13.00
16.00	01600	7,347	0	513,227			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	34,965	692,184	32,052	4,180,880	0	30.00
31.00	03100	13,470	266,639	12,679	1,639,349	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,891	0	59,288	1,513,809	0	50.00
51.00	05100	1,361	0	1,946	127,994	0	51.00
51.01	05101	2,993	59,253	11,368	450,681	0	51.01
54.00	05400	17,279	0	196,943	3,360,627	0	54.00
56.00	05600	0	0	0	192,328	0	56.00
60.00	06000	0	0	0	1,478,141	0	60.00
62.00	06200	0	0	0	92,413	0	62.00
65.00	06500	6,531	0	8,692	627,492	0	65.00
66.00	06600	6,395	0	14,291	871,641	0	66.00
67.00	06700	2,177	0	4,962	355,275	0	67.00
68.00	06800	272	0	919	56,132	0	68.00
69.00	06900	1,905	0	23,353	196,989	0	69.00
71.00	07100	0	0	0	164,088	0	71.00
72.00	07200	0	0	318	29,168	0	72.00
73.00	07300	7,211	0	0	1,718,729	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	272	0	0	18,672	0	90.00
91.00	09100	27,211	0	146,416	3,179,071	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		146,124	1,018,076	513,227	20,253,479	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	8,708	0	0	1,158,748	0	194.00
194.01	07951	0	0	0	461,363	0	194.01
200.00					0		200.00
201.00		0	0	0	0		201.00
202.00		154,832	1,018,076	513,227	21,873,590	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151326

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
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
5.01	00510 NONPATIENT TELEPHONES		5.01
5.02	00511 DATA PROCESSING		5.02
5.03	00512 PURCHASING RECEIVING AND STORES		5.03
5.04	00513 ADMITTING		5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL		5.06
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
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	4,180,880	30.00
31.00	03100 INTENSIVE CARE UNIT	1,639,349	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,513,809	50.00
51.00	05100 RECOVERY ROOM	127,994	51.00
51.01	05101 O/P TREATMENT ROOM	450,681	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,360,627	54.00
56.00	05600 RADIOISOTOPE	192,328	56.00
60.00	06000 LABORATORY	1,478,141	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	92,413	62.00
65.00	06500 RESPIRATORY THERAPY	627,492	65.00
66.00	06600 PHYSICAL THERAPY	871,641	66.00
67.00	06700 OCCUPATIONAL THERAPY	355,275	67.00
68.00	06800 SPEECH PATHOLOGY	56,132	68.00
69.00	06900 ELECTROCARDIOLOGY	196,989	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164,088	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	29,168	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,718,729	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	18,672	90.00
91.00	09100 EMERGENCY	3,179,071	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	20,253,479	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 PHYSICIAN PRACTICES	1,158,748	194.00
194.01	07951 MEDICAL OFFICE BUILDING	461,363	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	21,873,590	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
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	0	4.00
5.01 00510	NONPATIENT TELEPHONES	0	926	61,226	62,152	5.01
5.02 00511	DATA PROCESSING	0	2,705	370,022	372,727	5.02
5.03 00512	PURCHASING RECEIVING AND STORES	0	5,286	994	6,280	5.03
5.04 00513	ADMITTING	0	3,364	110	3,474	5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	1,710	2,652	0	4,362	5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	3,332	11,685	54,789	69,806	5.06
7.00 00700	OPERATION OF PLANT	2,160	192,525	31,777	226,462	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,768	1,433	4,201	8.00
9.00 00900	HOUSEKEEPING	0	3,489	8,695	12,184	9.00
10.00 01000	DIETARY	0	29,822	46,148	75,970	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,229	22,132	31,361	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,066	7,787	998	13,851	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	941	124,483	46,959	172,383	30.00
31.00 03100	INTENSIVE CARE UNIT	684	3,649	158,454	162,787	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	80,290	19,943	139,621	239,854	50.00
51.00 05100	RECOVERY ROOM	0	2,679	5,317	7,996	51.00
51.01 05101	O/P TREATMENT ROOM	0	14,310	11,745	26,055	51.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	419,209	39,050	89,707	547,966	54.00
56.00 05600	RADIOISOTOPE	0	2,341	0	2,341	56.00
60.00 06000	LABORATORY	127,884	15,227	0	143,111	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	30,624	4,040	27,066	61,730	65.00
66.00 06600	PHYSICAL THERAPY	539	30,071	51,957	82,567	66.00
67.00 06700	OCCUPATIONAL THERAPY	265	25,292	862	26,419	67.00
68.00 06800	SPEECH PATHOLOGY	0	3,417	0	3,417	68.00
69.00 06900	ELECTROCARDIOLOGY	31,393	3,186	20,929	55,508	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,498	9,042	0	12,540	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	104,161	9,024	2,759	115,944	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	712	0	712	90.00
91.00 09100	EMERGENCY	2,531	56,181	88,116	146,828	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	814,287	634,885	1,241,816	2,690,988	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	PHYSICIAN PRACTICES	1,791	19,329	1,253	22,373	194.00
194.01 07951	MEDICAL OFFICE BUILDING	0	80,628	0	80,628	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	816,078	734,842	1,243,069	2,793,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
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
5.01	00510	NONPATIENT TELEPHONES	62,152				5.01
5.02	00511	DATA PROCESSING	885	373,612			5.02
5.03	00512	PURCHASING RECEIVING AND STORES	442	2,524	9,246		5.03
5.04	00513	ADMITTING	1,327	15,146	15	19,962	5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	1,327	5,049	0	0	10,738
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	3,097	35,342	3	0	0
7.00	00700	OPERATION OF PLANT	5,751	68,161	1	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	54	0	0
9.00	00900	HOUSEKEEPING	221	2,524	502	0	0
10.00	01000	DIETARY	1,548	7,573	1	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	885	10,098	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,991	20,195	2	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,484	20,195	1,476	913	489
31.00	03100	INTENSIVE CARE UNIT	1,769	2,524	583	361	193
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,548	10,098	3,703	1,688	905
51.00	05100	RECOVERY ROOM	442	0	0	55	30
51.01	05101	O/P TREATMENT ROOM	1,106	2,524	240	324	173
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,318	22,720	688	5,594	3,039
56.00	05600	RADIOISOTOPE	221	0	9	217	116
60.00	06000	LABORATORY	1,106	2,524	0	2,806	1,504
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	22	12
65.00	06500	RESPIRATORY THERAPY	1,327	5,049	218	248	133
66.00	06600	PHYSICAL THERAPY	2,654	25,244	24	407	218
67.00	06700	OCCUPATIONAL THERAPY	1,769	0	0	141	76
68.00	06800	SPEECH PATHOLOGY	221	0	0	26	14
69.00	06900	ELECTROCARDIOLOGY	885	0	8	665	356
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	221	0	3	37	20
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9	5
73.00	07300	DRUGS CHARGED TO PATIENTS	1,106	7,573	41	2,111	1,131
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	221	0	0	4	2
91.00	09100	EMERGENCY	6,414	40,390	1,638	4,169	2,234
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,286	305,453	9,209	19,797	10,650
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	4,866	68,159	37	165	88
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	62,152	373,612	9,246	19,962	10,738

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
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
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING RECEIVING AND STORES					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	108,248				5.06
7.00	00700	OPERATION OF PLANT	9,230	309,605			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43	1,662	5,960		8.00
9.00	00900	HOUSEKEEPING	2,435	2,094	0	19,960	9.00
10.00	01000	DIETARY	2,352	17,904	0	1,168	106,516
11.00	01100	CAFETERIA	766	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,784	5,540	0	362	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,326	4,675	0	305	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,596	74,735	1,830	4,877	86,755
31.00	03100	INTENSIVE CARE UNIT	6,062	2,191	603	143	17,882
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,698	11,973	402	781	0
51.00	05100	RECOVERY ROOM	556	1,608	0	105	0
51.01	05101	O/P TREATMENT ROOM	1,486	8,591	0	561	1,879
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,675	23,444	530	1,530	0
56.00	05600	RADIOISOTOPE	898	1,405	0	92	0
60.00	06000	LABORATORY	6,968	9,142	0	597	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	457	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,938	2,426	0	158	0
66.00	06600	PHYSICAL THERAPY	3,518	18,053	454	1,178	0
67.00	06700	OCCUPATIONAL THERAPY	1,146	15,184	0	991	0
68.00	06800	SPEECH PATHOLOGY	194	2,052	0	134	0
69.00	06900	ELECTROCARDIOLOGY	776	1,913	78	125	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	606	5,428	0	354	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	143	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	8,264	5,418	0	354	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	75	427	0	28	0
91.00	09100	EMERGENCY	13,560	33,729	2,063	2,201	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	102,552	249,594	5,960	16,044	106,516
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	5,251	11,605	0	757	0
194.01	07951	MEDICAL OFFICE BUILDING	445	48,406	0	3,159	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	108,248	309,605	5,960	19,960	106,516

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	766					11.00
13.00	01300	44	53,074				13.00
16.00	01600	36	0	43,381			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	173	36,085	2,710	429,701	0	30.00
31.00	03100	67	13,900	1,072	210,137	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	39	0	5,013	282,702	0	50.00
51.00	05100	7	0	165	10,964	0	51.00
51.01	05101	15	3,089	961	47,004	0	51.01
54.00	05400	85	0	16,637	640,226	0	54.00
56.00	05600	0	0	0	5,299	0	56.00
60.00	06000	0	0	0	167,758	0	60.00
62.00	06200	0	0	0	491	0	62.00
65.00	06500	32	0	735	74,994	0	65.00
66.00	06600	32	0	1,208	135,557	0	66.00
67.00	06700	11	0	420	46,157	0	67.00
68.00	06800	1	0	78	6,137	0	68.00
69.00	06900	9	0	1,975	62,298	0	69.00
71.00	07100	0	0	0	19,209	0	71.00
72.00	07200	0	0	27	184	0	72.00
73.00	07300	36	0	0	141,978	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1	0	0	1,470	0	90.00
91.00	09100	135	0	12,380	265,741	0	91.00
92.00	09200					0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		723	53,074	43,381	2,548,007	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	43	0	0	113,344	0	194.00
194.01	07951	0	0	0	132,638	0	194.01
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		766	53,074	43,381	2,793,989	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151326

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
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
5.01	00510 NONPATIENT TELEPHONES		5.01
5.02	00511 DATA PROCESSING		5.02
5.03	00512 PURCHASING RECEIVING AND STORES		5.03
5.04	00513 ADMITTING		5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL		5.06
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
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	429,701	30.00
31.00	03100 INTENSIVE CARE UNIT	210,137	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	282,702	50.00
51.00	05100 RECOVERY ROOM	10,964	51.00
51.01	05101 O/P TREATMENT ROOM	47,004	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	640,226	54.00
56.00	05600 RADIOISOTOPE	5,299	56.00
60.00	06000 LABORATORY	167,758	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	491	62.00
65.00	06500 RESPIRATORY THERAPY	74,994	65.00
66.00	06600 PHYSICAL THERAPY	135,557	66.00
67.00	06700 OCCUPATIONAL THERAPY	46,157	67.00
68.00	06800 SPEECH PATHOLOGY	6,137	68.00
69.00	06900 ELECTROCARDIOLOGY	62,298	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,209	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	184	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	141,978	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1,470	90.00
91.00	09100 EMERGENCY	265,741	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,548,007	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 PHYSICIAN PRACTICES	113,344	194.00
194.01	07951 MEDICAL OFFICE BUILDING	132,638	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,793,989	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B-1

Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
	NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	82,573				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		393,733			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	9,206,006		4.00
5.01 00510	NONPATIENT TELEPHONES	104	19,393	0	281	5.01
5.02 00511	DATA PROCESSING	304	117,202	0	4	148 5.02
5.03 00512	PURCHASING RECEIVING AND STORES	594	315	0	2	1 5.03
5.04 00513	ADMITTING	378	35	296,905	6	6 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	298	0	21,307	6	2 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	1,313	17,354	534,573	14	14 5.06
7.00 00700	OPERATION OF PLANT	21,634	10,065	378,562	26	27 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	311	454	0	0	0 8.00
9.00 00900	HOUSEKEEPING	392	2,754	240,590	1	1 9.00
10.00 01000	DIETARY	3,351	14,617	216,885	7	3 10.00
11.00 01100	CAFETERIA	0	0	102,420	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,037	7,010	520,741	4	4 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	875	316	195,130	9	8 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,988	14,874	1,248,319	70	8 30.00
31.00 03100	INTENSIVE CARE UNIT	410	50,189	675,982	8	1 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,241	44,224	360,702	7	4 50.00
51.00 05100	RECOVERY ROOM	301	1,684	70,353	2	0 51.00
51.01 05101	O/P TREATMENT ROOM	1,608	3,720	148,700	5	1 51.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,388	28,414	1,362,944	15	9 54.00
56.00 05600	RADIOISOTOPE	263	0	0	1	0 56.00
60.00 06000	LABORATORY	1,711	0	0	5	1 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	454	8,573	298,690	6	2 65.00
66.00 06600	PHYSICAL THERAPY	3,379	16,457	265,115	12	10 66.00
67.00 06700	OCCUPATIONAL THERAPY	2,842	273	120,889	8	0 67.00
68.00 06800	SPEECH PATHOLOGY	384	0	18,169	1	0 68.00
69.00 06900	ELECTROCARDIOLOGY	358	6,629	109,784	4	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	0	1	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,014	874	398,612	5	3 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	80	0	9,202	1	0 90.00
91.00 09100	EMERGENCY	6,313	27,910	1,245,828	29	16 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	71,341	393,336	8,840,402	259	121 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	PHYSICIAN PRACTICES	2,172	397	365,604	22	27 194.00
194.01 07951	MEDICAL OFFICE BUILDING	9,060	0	0	0	0 194.01
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)	734,842	1,243,069	1,349,692	123,369	2,004,258 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	8.899301	3.157137	0.146610	439.035587	13,542.283784 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0	62,152	373,612 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000	221.181495	2,524.405405 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B-1

Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (REQUISITION)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
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
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING RECEIVING AND STORES	501,863				5.03
5.04	00513	ADMITTING	832	68,180,964			5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	0	0	68,180,964		5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	165	0	0	-2,249,441	19,624,149
7.00	00700	OPERATION OF PLANT	63	0	0	0	1,673,366
8.00	00800	LAUNDRY & LINEN SERVICE	2,955	0	0	0	7,793
9.00	00900	HOUSEKEEPING	27,223	0	0	0	441,482
10.00	01000	DIETARY	39	0	0	0	426,460
11.00	01100	CAFETERIA	0	0	0	0	138,909
13.00	01300	NURSING ADMINISTRATION	20	0	0	0	867,296
16.00	01600	MEDICAL RECORDS & LIBRARY	110	0	0	0	421,668
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	80,108	3,115,146	3,115,146	0	2,102,332
31.00	03100	INTENSIVE CARE UNIT	31,632	1,232,290	1,232,290	0	1,099,013
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	201,016	5,762,290	5,762,290	0	1,214,290
51.00	05100	RECOVERY ROOM	19	189,147	189,147	0	100,792
51.01	05101	O/P TREATMENT ROOM	13,013	1,104,825	1,104,825	0	269,439
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,323	19,142,705	19,142,705	0	2,659,918
56.00	05600	RADIOISOTOPE	482	740,885	740,885	0	162,874
60.00	06000	LABORATORY	0	9,576,473	9,576,473	0	1,263,190
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	73,976	73,976	0	82,909
65.00	06500	RESPIRATORY THERAPY	11,811	844,831	844,831	0	532,603
66.00	06600	PHYSICAL THERAPY	1,320	1,388,916	1,388,916	0	637,864
67.00	06700	OCCUPATIONAL THERAPY	4	482,216	482,216	0	207,785
68.00	06800	SPEECH PATHOLOGY	0	89,343	89,343	0	35,164
69.00	06900	ELECTROCARDIOLOGY	440	2,269,677	2,269,677	0	140,682
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141	125,993	125,993	0	109,838
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,942	30,942	0	25,883
73.00	07300	DRUGS CHARGED TO PATIENTS	2,221	7,205,750	7,205,750	0	1,498,207
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	13,747	13,747	0	13,565
91.00	09100	EMERGENCY	88,899	14,230,325	14,230,325	0	2,458,328
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	499,836	67,619,477	67,619,477	-2,249,441	18,591,650
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	2,027	561,487	561,487	0	951,871
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	80,628
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	132,899	555,231	979,989		2,249,441
203.00		Unit cost multiplier (wkst. B, Part I)	0.264811	0.008143	0.014373		0.114626
204.00		Cost to be allocated (per wkst. B, Part II)	9,246	19,962	10,738		108,248
205.00		Unit cost multiplier (wkst. B, Part II)	0.018423	0.000293	0.000157		0.005516

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B-1

Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (SQ FT)	DIETARY (DIETARY)	CAFETERIA (FTE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
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
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING RECEIVING AND STORES					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	57,948				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	311	44,127			8.00
9.00	00900	HOUSEKEEPING	392	0	57,245		9.00
10.00	01000	DIETARY	3,351	0	3,351	8,220	10.00
11.00	01100	CAFETERIA	0	0	0	1,138	11.00
13.00	01300	NURSING ADMINISTRATION	1,037	0	1,037	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,988	13,548	13,988	6,695	257
31.00	03100	INTENSIVE CARE UNIT	410	4,464	410	1,380	99
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,241	2,978	2,241	0	58
51.00	05100	RECOVERY ROOM	301	0	301	0	10
51.01	05101	O/P TREATMENT ROOM	1,608	1	1,608	145	22
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,388	3,924	4,388	0	127
56.00	05600	RADIOISOTOPE	263	0	263	0	0
60.00	06000	LABORATORY	1,711	0	1,711	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	454	0	454	0	48
66.00	06600	PHYSICAL THERAPY	3,379	3,360	3,379	0	47
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	16
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	2
69.00	06900	ELECTROCARDIOLOGY	358	575	358	0	14
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	1,016	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,014	0	1,014	0	53
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	80	0	80	0	2
91.00	09100	EMERGENCY	6,313	15,277	6,313	0	200
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,716	44,127	46,013	8,220	1,074
NONREIMBURSABLE COST CENTERS							
194.00	07950	PHYSICIAN PRACTICES	2,172	0	2,172	0	64
194.01	07951	MEDICAL OFFICE BUILDING	9,060	0	9,060	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	1,865,177	18,696	504,704	612,746	154,832
203.00		Unit cost multiplier (wkst. B, Part I)	32.187082	0.423686	8.816560	74.543309	136.056239
204.00		Cost to be allocated (per wkst. B, Part II)	309,605	5,960	19,960	106,516	766
205.00		Unit cost multiplier (wkst. B, Part II)	5.342807	0.135065	0.348677	12.958151	0.673111

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet B-1

Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (USER REVENUE)	
		13.00	16.00	
GENERAL SERVICE COST CENTERS				
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
5.01	00510 NONPATIENT TELEPHONES			5.01
5.02	00511 DATA PROCESSING			5.02
5.03	00512 PURCHASING RECEIVING AND STORES			5.03
5.04	00513 ADMITTING			5.04
5.05	00514 CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL			5.06
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	378		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	49,882,653	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	257	3,115,146	30.00
31.00	03100 INTENSIVE CARE UNIT	99	1,232,290	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	5,762,290	50.00
51.00	05100 RECOVERY ROOM	0	189,147	51.00
51.01	05101 O/P TREATMENT ROOM	22	1,104,825	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	19,142,705	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	844,831	65.00
66.00	06600 PHYSICAL THERAPY	0	1,388,916	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	482,216	67.00
68.00	06800 SPEECH PATHOLOGY	0	89,343	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,269,677	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	30,942	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	14,230,325	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	378	49,882,653	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950 PHYSICIAN PRACTICES	0	0	194.00
194.01	07951 MEDICAL OFFICE BUILDING	0	0	194.01
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,018,076	513,227	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	2,693.322751	0.010289	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	53,074	43,381	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	140.407407	0.000870	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Total Costs
			Total Costs	Costs		Total Costs	
				RCE Disallowance			
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	4,180,880		4,180,880	0		0	30.00
31.00 03100 INTENSIVE CARE UNIT	1,639,349		1,639,349	0		0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,513,809		1,513,809	0		0	50.00
51.00 05100 RECOVERY ROOM	127,994		127,994	0		0	51.00
51.01 05101 O/P TREATMENT ROOM	450,681		450,681	0		0	51.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,360,627		3,360,627	0		0	54.00
56.00 05600 RADIOISOTOPE	192,328		192,328	0		0	56.00
60.00 06000 LABORATORY	1,478,141		1,478,141	0		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	92,413		92,413	0		0	62.00
65.00 06500 RESPIRATORY THERAPY	627,492	0	627,492	0		0	65.00
66.00 06600 PHYSICAL THERAPY	871,641	0	871,641	0		0	66.00
67.00 06700 OCCUPATIONAL THERAPY	355,275	0	355,275	0		0	67.00
68.00 06800 SPEECH PATHOLOGY	56,132	0	56,132	0		0	68.00
69.00 06900 ELECTROCARDIOLOGY	196,989		196,989	0		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164,088		164,088	0		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	29,168		29,168	0		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,718,729		1,718,729	0		0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	18,672		18,672	0		0	90.00
91.00 09100 EMERGENCY	3,179,071		3,179,071	0		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,183,436		1,183,436				92.00
200.00 Subtotal (see instructions)	21,436,915	0	21,436,915	0		0	200.00
201.00 Less Observation Beds	1,183,436		1,183,436				201.00
202.00 Total (see instructions)	20,253,479	0	20,253,479	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/30/2013 4:42 pm
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Cost Center Description	Title XVIII			Hospital	Cost		
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,115,146		3,115,146		30.00
31.00	03100	INTENSIVE CARE UNIT	1,232,290		1,232,290		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,843,001	3,919,289	5,762,290	0.262710	50.00
51.00	05100	RECOVERY ROOM	55,740	133,407	189,147	0.676691	51.00
51.01	05101	O/P TREATMENT ROOM	3,031	1,101,794	1,104,825	0.407921	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,823,084	17,319,621	19,142,705	0.175557	54.00
56.00	05600	RADIOISOTOPE	44,443	696,442	740,885	0.259592	56.00
60.00	06000	LABORATORY	1,801,153	7,775,320	9,576,473	0.154351	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	42,377	31,599	73,976	1.249229	62.00
65.00	06500	RESPIRATORY THERAPY	603,253	241,578	844,831	0.742743	65.00
66.00	06600	PHYSICAL THERAPY	136,516	1,252,400	1,388,916	0.627569	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,604	435,612	482,216	0.736755	67.00
68.00	06800	SPEECH PATHOLOGY	15,255	74,088	89,343	0.628275	68.00
69.00	06900	ELECTROCARDIOLOGY	542,850	1,726,827	2,269,677	0.086792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,618	18,375	125,993	1.302358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	998	29,944	30,942	0.942667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,575,440	3,630,310	7,205,750	0.238522	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	13,747	13,747	1.358260	90.00
91.00	09100	EMERGENCY	792,645	13,437,679	14,230,324	0.223401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,339,088	1,339,088	0.883763	92.00
200.00		Subtotal (see instructions)	15,781,444	53,177,120	68,958,564		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,781,444	53,177,120	68,958,564		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet C
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	4,180,880		4,180,880	0	0		30.00
31.00	03100 INTENSIVE CARE UNIT	1,639,349		1,639,349	0	0		31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	1,513,809		1,513,809	0	0		50.00
51.00	05100 RECOVERY ROOM	127,994		127,994	0	0		51.00
51.01	05101 O/P TREATMENT ROOM	450,681		450,681	0	0		51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,360,627		3,360,627	0	0		54.00
56.00	05600 RADIOISOTOPE	192,328		192,328	0	0		56.00
60.00	06000 LABORATORY	1,478,141		1,478,141	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	92,413		92,413	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	627,492	0	627,492	0	0		65.00
66.00	06600 PHYSICAL THERAPY	871,641	0	871,641	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	355,275	0	355,275	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	56,132	0	56,132	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	196,989		196,989	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164,088		164,088	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	29,168		29,168	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,718,729		1,718,729	0	0		73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	18,672		18,672	0	0		90.00
91.00	09100 EMERGENCY	3,179,071		3,179,071	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,183,436		1,183,436	0	0		92.00
200.00	Subtotal (see instructions)	21,436,915	0	21,436,915	0	0		200.00
201.00	Less Observation Beds	1,183,436		1,183,436	0	0		201.00
202.00	Total (see instructions)	20,253,479	0	20,253,479	0	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

worksheet C
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Charges			Hospital	Cost	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,115,146		3,115,146			30.00
31.00	03100	INTENSIVE CARE UNIT	1,232,290		1,232,290			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,843,001	3,919,289	5,762,290	0.262710	0.000000	50.00
51.00	05100	RECOVERY ROOM	55,740	133,407	189,147	0.676691	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	3,031	1,101,794	1,104,825	0.407921	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,823,084	17,319,621	19,142,705	0.175557	0.000000	54.00
56.00	05600	RADIOISOTOPE	44,443	696,442	740,885	0.259592	0.000000	56.00
60.00	06000	LABORATORY	1,801,153	7,775,320	9,576,473	0.154351	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	42,377	31,599	73,976	1.249229	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	603,253	241,578	844,831	0.742743	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	136,516	1,252,400	1,388,916	0.627569	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,604	435,612	482,216	0.736755	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,255	74,088	89,343	0.628275	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	542,850	1,726,827	2,269,677	0.086792	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,618	18,375	125,993	1.302358	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	998	29,944	30,942	0.942667	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,575,440	3,630,310	7,205,750	0.238522	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	13,747	13,747	1.358260	0.000000	90.00
91.00	09100	EMERGENCY	792,645	13,437,679	14,230,324	0.223401	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,339,088	1,339,088	0.883763	0.000000	92.00
200.00		Subtotal (see instructions)	15,781,444	53,177,120	68,958,564			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,781,444	53,177,120	68,958,564			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D
Part II
Date/Time Prepared:
1/30/2013 4:42 pm

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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	282,702	5,762,290	0.049061	638,613	31,331	50.00
51.00	05100	RECOVERY ROOM	10,964	189,147	0.057965	18,393	1,066	51.00
51.01	05101	O/P TREATMENT ROOM	47,004	1,104,825	0.042544	1,405	60	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	640,226	19,142,705	0.033445	532,122	17,797	54.00
56.00	05600	RADIOISOTOPE	5,299	740,885	0.007152	37,817	270	56.00
60.00	06000	LABORATORY	167,758	9,576,473	0.017518	763,131	13,369	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	491	73,976	0.006637	22,248	148	62.00
65.00	06500	RESPIRATORY THERAPY	74,994	844,831	0.088768	256,924	22,807	65.00
66.00	06600	PHYSICAL THERAPY	135,557	1,388,916	0.097599	77,571	7,571	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,157	482,216	0.095719	23,870	2,285	67.00
68.00	06800	SPEECH PATHOLOGY	6,137	89,343	0.068690	12,648	869	68.00
69.00	06900	ELECTROCARDIOLOGY	62,298	2,269,677	0.027448	317,286	8,709	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,209	125,993	0.152461	78,891	12,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	184	30,942	0.005947	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	141,978	7,205,750	0.019703	1,858,287	36,614	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,470	13,747	0.106932	0	0	90.00
91.00	09100	EMERGENCY	265,741	14,230,324	0.018674	27	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,339,088	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,908,169	64,611,128		4,639,233	154,925	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D
Part IV
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description	Title XVIII				Hospital	Cost	Total Cost (sum of col 1 through col. 4) 5.00
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D
Part IV
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Cost
			Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	5,762,290	0.000000	0.000000	638,613	50.00
51.00	05100 RECOVERY ROOM	0	189,147	0.000000	0.000000	18,393	51.00
51.01	05101 O/P TREATMENT ROOM	0	1,104,825	0.000000	0.000000	1,405	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	19,142,705	0.000000	0.000000	532,122	54.00
56.00	05600 RADIOISOTOPE	0	740,885	0.000000	0.000000	37,817	56.00
60.00	06000 LABORATORY	0	9,576,473	0.000000	0.000000	763,131	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	73,976	0.000000	0.000000	22,248	62.00
65.00	06500 RESPIRATORY THERAPY	0	844,831	0.000000	0.000000	256,924	65.00
66.00	06600 PHYSICAL THERAPY	0	1,388,916	0.000000	0.000000	77,571	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	482,216	0.000000	0.000000	23,870	67.00
68.00	06800 SPEECH PATHOLOGY	0	89,343	0.000000	0.000000	12,648	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,269,677	0.000000	0.000000	317,286	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125,993	0.000000	0.000000	78,891	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	30,942	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,205,750	0.000000	0.000000	1,858,287	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	13,747	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	14,230,324	0.000000	0.000000	27	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,339,088	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	64,611,128			4,639,233	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/30/2013 4:42 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Hospital	Cost	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
							1.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.262710	0	1,281,729	0	50.00
51.00	05100	RECOVERY ROOM	0.676691	0	31,743	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.407921	0	1,063,726	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175557	0	5,116,516	0	54.00
56.00	05600	RADIOISOTOPE	0.259592	0	253,794	0	56.00
60.00	06000	LABORATORY	0.154351	0	3,036,243	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.249229	0	21,988	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.742743	0	183,923	0	65.00
66.00	06600	PHYSICAL THERAPY	0.627569	0	464,311	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.736755	0	177,977	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.628275	0	6,940	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086792	0	781,358	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.302358	0	13,853	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.942667	0	2,029	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238522	0	1,826,531	5,624	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.358260	0	10,572	0	90.00
91.00	09100	EMERGENCY	0.223401	0	3,895,341	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.883763	0	1,284	0	92.00
200.00		Subtotal (see instructions)		0	18,169,858	5,624	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	18,169,858	5,624	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D
Part V
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Costs				
		PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	336,723	0	50.00
51.00	05100	RECOVERY ROOM	0	21,480	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	433,916	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	898,240	0	54.00
56.00	05600	RADIOISOTOPE	0	65,883	0	56.00
60.00	06000	LABORATORY	0	468,647	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	27,468	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	136,608	0	65.00
66.00	06600	PHYSICAL THERAPY	0	291,387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131,125	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,360	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	67,816	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,042	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,913	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	435,668	1,341	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	14,360	0	90.00
91.00	09100	EMERGENCY	0	870,223	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,135	0	92.00
200.00		Subtotal (see instructions)	0	4,224,994	1,341	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,224,994	1,341	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D-1

Date/Time Prepared:
1/30/2013 4:42 pm

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,335	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,161	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)	2,217	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	174	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,308	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)	146	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,180,880	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)	218,133	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,962,747	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,277,543	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,277,543	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.926407	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)	1,929.43	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)	3,962,747	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,253.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,639,761	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,639,761	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D-1

Date/Time Prepared:
1/30/2013 4:42 pm

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)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	1,639,349	493	3,325.25	256	851,264 43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,268,179 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,759,204 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					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 anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					183,031 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					183,031 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 + line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					944 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,253.64 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,183,436 89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/30/2013 4:42 pm
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Cost Center Description	Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,335 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,161 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)		2,217 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		174 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		261 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)		4,180,880 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)		218,133 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,962,747 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,277,543 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,277,543 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.926407 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)		1,929.43 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)		3,962,747 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,253.64 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		327,200 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)		327,200 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet D-1
Date/Time Prepared:
1/30/2013 4:42 pm

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)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,639,349	493	3,325.25	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					389,246	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					716,446	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					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 anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					944	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,253.64	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,183,436	89.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/30/2013 4:42 pm
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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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,742,425		30.00
31.00	03100 INTENSIVE CARE UNIT		638,720		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.262710	638,613	167,770	50.00
51.00	05100 RECOVERY ROOM	0.676691	18,393	12,446	51.00
51.01	05101 O/P TREATMENT ROOM	0.407921	1,405	573	51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175557	532,122	93,418	54.00
56.00	05600 RADIOISOTOPE	0.259592	37,817	9,817	56.00
60.00	06000 LABORATORY	0.154351	763,131	117,790	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.249229	22,248	27,793	62.00
65.00	06500 RESPIRATORY THERAPY	0.742743	256,924	190,829	65.00
66.00	06600 PHYSICAL THERAPY	0.627569	77,571	48,681	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.736755	23,870	17,586	67.00
68.00	06800 SPEECH PATHOLOGY	0.628275	12,648	7,946	68.00
69.00	06900 ELECTROCARDIOLOGY	0.086792	317,286	27,538	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.302358	78,891	102,744	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.942667	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.238522	1,858,287	443,242	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.358260	0	0	90.00
91.00	09100 EMERGENCY	0.223401	27	6	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.883763	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,639,233	1,268,179	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)		4,639,233		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	worksheet D-3
		Component CCN: 152326	Date/Time Prepared: 1/30/2013 4:42 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.262710	313	82 50.00
51.00	05100 RECOVERY ROOM	0.676691	0	0 51.00
51.01	05101 O/P TREATMENT ROOM	0.407921	0	0 51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175557	4,966	872 54.00
56.00	05600 RADIOISOTOPE	0.259592	425	110 56.00
60.00	06000 LABORATORY	0.154351	13,432	2,073 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.249229	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.742743	13,326	9,898 65.00
66.00	06600 PHYSICAL THERAPY	0.627569	25,240	15,840 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.736755	12,900	9,504 67.00
68.00	06800 SPEECH PATHOLOGY	0.628275	250	157 68.00
69.00	06900 ELECTROCARDIOLOGY	0.086792	740	64 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.302358	1,438	1,873 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.942667	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.238522	56,203	13,406 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.358260	0	0 90.00
91.00	09100 EMERGENCY	0.223401	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.883763	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		129,233	53,879 200.00
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)		129,233	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/30/2013 4:42 pm
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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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		321,516	30.00
31.00	03100 INTENSIVE CARE UNIT		122,255	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.262710	281,752	74,019 50.00
51.00	05100 RECOVERY ROOM	0.676691	7,656	5,181 51.00
51.01	05101 O/P TREATMENT ROOM	0.407921	0	0 51.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175557	286,401	50,280 54.00
56.00	05600 RADIOISOTOPE	0.259592	3,656	949 56.00
60.00	06000 LABORATORY	0.154351	254,884	39,342 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.249229	7,022	8,772 62.00
65.00	06500 RESPIRATORY THERAPY	0.742743	18,339	13,621 65.00
66.00	06600 PHYSICAL THERAPY	0.627569	8,651	5,429 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.736755	2,335	1,720 67.00
68.00	06800 SPEECH PATHOLOGY	0.628275	250	157 68.00
69.00	06900 ELECTROCARDIOLOGY	0.086792	46,295	4,018 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.302358	26,139	34,042 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.942667	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.238522	424,561	101,267 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.358260	0	0 90.00
91.00	09100 EMERGENCY	0.223401	225,821	50,449 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.883763	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,593,762	389,246 200.00
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)		1,593,762	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3
		Component CCN: 15Z326		Date/Time Prepared: 1/30/2013 4:42 pm

Cost Center Description		Title XIX		Swing Beds - SNF		Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)			
		1.00	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		0			30.00
31.00	03100	INTENSIVE CARE UNIT		0			31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.262710	0	0		50.00
51.00	05100	RECOVERY ROOM	0.676691	0	0		51.00
51.01	05101	O/P TREATMENT ROOM	0.407921	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175557	0	0		54.00
56.00	05600	RADIOISOTOPE	0.259592	0	0		56.00
60.00	06000	LABORATORY	0.154351	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.249229	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0.742743	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.627569	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.736755	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.628275	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.086792	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.302358	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.942667	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238522	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.358260	0	0		90.00
91.00	09100	EMERGENCY	0.223401	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.883763	0	0		92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0		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)		0	0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/30/2013 4:42 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,226,335 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)			4,226,335 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
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
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			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)			4,268,598 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
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			47,462 25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			2,986,628 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,234,508 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,234,508 30.00
31.00	Primary payer payments			1,200 31.00
32.00	Subtotal (line 30 minus line 31)			1,233,308 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			574,948 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			574,948 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			373,078 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,808,256 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,808,256 40.00
41.00	Interim payments			3,486,395 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)			-1,678,139 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			139,695 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
1/30/2013 4:42 pm

		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		2,994,187		2,489,591	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/31/2012	129,915	08/31/2012	801,594	3.01	
3.02			0	04/10/2012	177,467	3.02	
3.03			0	07/03/2012	17,743	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/10/2012	28,568		0	3.50	
3.51		07/03/2012	6,622		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)		94,725		996,804	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)		3,088,912		3,486,395	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		361,310		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		1,678,139	6.02	
7.00	Total Medicare program liability (see instructions)		3,450,222		1,808,256	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: 151326

Period: From 09/01/2011

Worksheet E-1

Component CCN: 152326

To 08/31/2012

Part I

Date/Time Prepared: 1/30/2013 4:42 pm

		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		234,576		0
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
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)				0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/10/2012	11,761		0
3.51		07/03/2012	888		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-12,649		0
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)		221,927		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				0
6.01	SETTLEMENT TO PROVIDER		17,352		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		239,279		0
			0	Contractor Number 1.00	Date (Mo/Day/Yr) 2.00
8.00	Name of Contractor				0

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151326	Period: From 09/01/2011 to 08/31/2012	Worksheet E-1 Part II Date/Time Prepared: 1/30/2013 4:42 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			1,344 1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,564 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			2,710 4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			68,958,564 5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			3,576,037 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			0 32.00
				overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet E-2	
		Component CCN: 152326	Date/Time Prepared: 1/30/2013 4:42 pm		
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		184,861	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)		54,418	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		146	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)		239,279	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		239,279	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)		239,279	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	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)		239,279	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)		239,279	0	19.00
20.00	Interim payments		221,927	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)		17,352	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		7,828	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part V Date/Time Prepared: 1/30/2013 4:42 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			3,759,204 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)			3,759,204 4.00
5.00	Primary payer payments			477 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,796,319 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
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
Customary charges				
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
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)			3,796,319 19.00
20.00	Deductibles (exclude professional component)			446,036 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,350,283 22.00
23.00	Coinsurance			5,726 23.00
24.00	Subtotal (line 22 minus line 23)			3,344,557 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			105,665 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			105,665 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			63,400 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,450,222 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)			3,450,222 30.00
31.00	Interim payments			3,088,912 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)			361,310 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			124,244 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part V Date/Time Prepared: 1/30/2013 4:42 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		3,759,204	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)		3,759,204	4.00
5.00	Primary payer payments		477	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,796,319	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
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
Customary charges				
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
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		3,796,319	19.00
20.00	Deductibles (exclude professional component)		446,036	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		3,350,283	22.00
23.00	Coinsurance		5,726	23.00
24.00	Subtotal (line 22 minus line 23)		3,344,557	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		105,665	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		105,665	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		63,400	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,450,222	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)		3,450,222	30.00
31.00	Interim payments		3,088,912	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)		361,310	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		124,244	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151326	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 1/30/2013 4:42 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		716,446	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)		716,446	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)		716,446	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		1,593,762	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)		1,593,762	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		1,593,762	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		877,316	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		716,446	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		716,446	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		716,446	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		716,446	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		716,446	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		716,446	40.00
41.00	Interim payments		792,418	41.00
42.00	Balance due provider/program (line 40 minus 41)		-75,972	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		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: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet G

Date/Time Prepared:
1/30/2013 4:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	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	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	0	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,825,012	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,825,012	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,825,012	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,825,012				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,825,012	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,825,012	0	0	0	60.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/30/2013 4:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,001,308		3,001,308	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	113,838		113,838	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)	3,115,146		3,115,146	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,232,290		1,232,290	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)	1,232,290		1,232,290	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,347,436		4,347,436	17.00
18.00	Ancillary services	11,648,896	55,615,173	67,264,069	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)	15,996,332	55,615,173	71,611,505	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		18,226,139		29.00
30.00	BENEFITS	1,210,273			30.00
31.00	PHOENIX ALLOCATION	176,871			31.00
32.00	IS ALLOCATION	319,200			32.00
33.00	PERSONNEL COST ALLOCATION	277,326			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,983,670		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)		20,209,809		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151326

Period:
From 09/01/2011
To 08/31/2012

worksheet G-3

Date/Time Prepared:
1/30/2013 4:42 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	71,611,505	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,232,704	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,378,801	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	20,209,809	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,168,992	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	371,874	24.00
25.00	Total other income (sum of lines 6-24)	371,874	25.00
26.00	Total (line 5 plus line 25)	5,540,866	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)	5,540,866	29.00

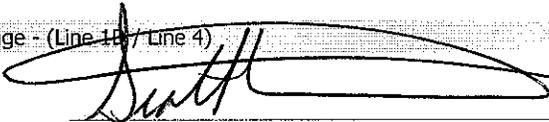
CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 1/29/2013 4:20:57 PM
 Data File: C:\Tammie Documents\151326cr2012.mcrx
 Fiscal Year: 09/01/2011 To 08/31/2012
 Provider Name: UNION HOSPITAL CLINTON
 Provider No: 151326

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours
Department: DISCH PLAN/UTIL REVIEW
Physician: PROCARE
Provider: UNION HOSPITAL CLINTON
Number: 151326
Specialty: GENERAL PRACTICE

Basis of Allocation: Other **Describe:** CONTRACTUAL

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	260.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	260.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	0.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	260.00
5. Professional Component Percentage (Line 2 / Line 4)	0.00 %
6. Provider Component Percentage - (Line 1B / Line 4)	100.00 %


 Signature: Physician or Physician Department Head

January 31, 2013
 Date

v7

CMS 339 Questionnaire - Exhibit 2 INPATIENT
Date Prepared: 1/29/2013 4:23:01 PM
Data File: C:\Tammie Documents\151326cr2012.mcrx
Fiscal Year: 09/01/2011 To 08/31/2012
Provider Name: UNION HOSPITAL CLINTON
Provider No: 151326

Health Financial Systems
MCRIF32

Provider: UNION HOSPITAL CLINTON
Number: 151326

Prepared By:
Date Prepared:
Type: INPATIENT

PATIENT NAME	HIC. NO.	DATES OF SERVICE		INDEGENCY & WEL. RECIP. (CK IF APPL)	
		FROM	TO	YES	MEDICAID NUMBER
SEE ATTACHED					

CMS 339 Questionnaire - Exhibit 2 OUTPATIENT
Date Prepared: 1/29/2013 4:20:57 PM
Data File: C:\Tammie Documents\151326cr2012.mcrx
Fiscal Year: 09/01/2011 To 08/31/2012
Provider Name: UNION HOSPITAL CLINTON
Provider No: 151326

Health Financial Systems
MCRIF32

Provider: UNION HOSPITAL CLINTON
Number: 151326

Prepared By:
Date Prepared:
Type: OUTPATIENT

PATIENT NAME	HIC. NO.	DATES OF SERVICE		INDEGENCY & WEL. RECIP. (CK IF APPL)	
		FROM	TO	YES	MEDICAID NUMBER

SEE ATTACHED