

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012 Worksheet S Parts I-III Date/Time Prepared: 5/30/2013 4:36 pm

<b>PART I - COST REPORT STATUS</b>		
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2013 Time: 4:36 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 DUKES MEMORIAL HOSPITAL ( 151318 ) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	331,753	-634,031	1,643,307	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	117,101	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	448,854	-634,031	1,643,307	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 4:28 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 275 WEST 12TH STREET		PO Box:						1.00		
2.00	City: PERU		State: IN		Zip Code: 46970		County: MIAMI		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		DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	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		DUKES MEMORIAL HOSPITAL SB	152318	99915		12/01/2003	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012		20.00		
21.00	Type of Control (see instructions)					4			21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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	0	0	0	24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0	25.00		
						Urban/Rural	Date of Geogr				
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 4:28 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151318

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N			
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		
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		
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		
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		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	42,994	78,719	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	
<b>Transplant Center Information</b>				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	
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.			
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.			
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.			
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.			
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.			
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	449008
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS		Contractor's Number: 52280
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		
143.00	City: FRANKLIN	State: TN		Zip Code: 37067
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y	
			1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	
		Part A	Part B	Title V
		1.00	2.00	3.00
				Title XIX
				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
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N

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							1.00	
<b>Multi campus</b>								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						2,037,109	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 4:28 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/13/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 4:28 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			Y	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RYAN	NELSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7553	RYAN_NELSON@CHS.NET		43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/13/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151318

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,686	77,712.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	77,712.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	14,568.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	92,280.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151318

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,815	203	3,238			1.00
2.00 HMO	223	473				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	528	0	580			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,343	203	3,818			7.00
8.00 INTENSIVE CARE UNIT	285	19	607			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		51	476			13.00
14.00 Total (see instructions)	2,628	273	4,901	0.00	252.50	14.00
15.00 CAH visits	12,281	8,069	41,112			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	252.50	27.00
28.00 Observation Bed Days		0	940			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151318

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	585	100	1,193	1.00
2.00 HMO			60			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	585	100	1,193	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					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/30/2013 4:28 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.251403	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			2,496,679	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			524,616	5.00	
6.00	Medicaid charges			18,673,742	6.00	
7.00	Medicaid cost (line 1 times line 6)			4,694,635	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,673,340	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)			558,155	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			2,970,058	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			746,681	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)			188,526	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)			1,861,866	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			402,604	29,355	431,959
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			101,216	7,380	108,596
22.00	Partial payment by patients approved for charity care			14,100	368	14,468
23.00	Cost of charity care (line 21 minus line 22)			87,116	7,012	94,128
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit					0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,256,362		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			351,171		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			3,905,191		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			981,777		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,075,905		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,937,771		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151318

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

Worksheet A  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		601,436	601,436	378,778	980,214	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,452,720	1,452,720	455,425	1,908,145	2.00
4.00	00400	EMPLOYEE BENEFITS	89,621	44,781	134,402	1,437,678	1,572,080	4.00
5.01	00540	ADMITTING	0	0	0	6,352,921	6,352,921	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,995,040	11,442,577	13,437,617	-8,260,391	5,177,226	5.02
7.00	00700	OPERATION OF PLANT	224,704	996,886	1,221,590	2,147	1,223,737	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,773	97,773	0	97,773	8.00
9.00	00900	HOUSEKEEPING	253,005	63,095	316,100	0	316,100	9.00
10.00	01000	DIETARY	187,344	169,879	357,223	-186,958	170,265	10.00
11.00	01100	CAFETERIA	0	0	0	185,693	185,693	11.00
13.00	01300	NURSING ADMINISTRATION	317,924	81,256	399,180	-164,962	234,218	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,843	382,357	455,200	-230,785	224,415	14.00
15.00	01500	PHARMACY	343,098	962,846	1,305,944	-795,919	510,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	121,148	227,807	348,955	81,152	430,107	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,588,799	673,402	2,262,201	-67,583	2,194,618	30.00
31.00	03100	INTENSIVE CARE UNIT	366,061	41,792	407,853	-1,225	406,628	31.00
43.00	04300	NURSERY	0	0	0	57,224	57,224	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	370,126	868,909	1,239,035	-129,606	1,109,429	50.00
51.00	05100	RECOVERY ROOM	192,481	28,732	221,213	-93	221,120	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	510,002	193,852	703,854	580,049	1,283,903	54.00
54.01	05401	ULTRASOUND	106,479	15,601	122,080	-122,080	0	54.01
56.00	05600	RADIOISOTOPE	67,829	147,295	215,124	-215,124	0	56.00
57.00	05700	CT SCAN	42,735	201,512	244,247	-244,247	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	42,413	102,314	144,727	-144,727	0	58.00
60.00	06000	LABORATORY	610,486	782,957	1,393,443	-66,234	1,327,209	60.00
65.00	06500	RESPIRATORY THERAPY	335,335	41,840	377,175	-1,007	376,168	65.00
66.00	06600	PHYSICAL THERAPY	1,479	449,838	451,317	-926	450,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	218,185	218,185	0	218,185	67.00
68.00	06800	SPEECH PATHOLOGY	0	144,593	144,593	0	144,593	68.00
69.00	06900	ELECTROCARDIOLOGY	140,075	24,638	164,713	-1,105	163,608	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	161,763	161,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	127,972	127,972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	717,883	717,883	73.00
76.00	03020	SLEEP LAB	123,267	21,535	144,802	-2,677	142,125	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	244,341	62,387	306,728	-3,043	303,685	90.00
91.00	09100	EMERGENCY	2,546,779	1,047,176	3,593,955	-3,220	3,590,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	202,051	123,980	326,031	-3,538	322,493	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,095,465	21,713,951	32,809,416	-106,765	32,702,651	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	373	9,507	9,880	-9,880	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	114,092	114,092	194.01
194.02	07952	SENIOR CIRCLE	0	-2,553	-2,553	2,553	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	11,095,838	21,720,905	32,816,743	0	32,816,743	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151318

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

Worksheet A  
Date/Time Prepared:  
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	327,869	1,308,083	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	24,317	1,932,462	2.00
4.00	00400	EMPLOYEE BENEFITS	-1,502	1,570,578	4.00
5.01	00540	ADMINISTRATIVE	-5,141,815	1,211,106	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-469,526	4,707,700	5.02
7.00	00700	OPERATION OF PLANT	26,895	1,250,632	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,180	113,953	8.00
9.00	00900	HOUSEKEEPING	0	316,100	9.00
10.00	01000	DIETARY	0	170,265	10.00
11.00	01100	CAFETERIA	-68,882	116,811	11.00
13.00	01300	NURSING ADMINISTRATION	-3,255	230,963	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	224,415	14.00
15.00	01500	PHARMACY	0	510,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,591	419,516	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-368,000	1,826,618	30.00
31.00	03100	INTENSIVE CARE UNIT	0	406,628	31.00
43.00	04300	NURSERY	0	57,224	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-424,510	684,919	50.00
51.00	05100	RECOVERY ROOM	0	221,120	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,706	1,282,197	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOLOGY	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	1,327,209	60.00
65.00	06500	RESPIRATORY THERAPY	0	376,168	65.00
66.00	06600	PHYSICAL THERAPY	0	450,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	218,185	67.00
68.00	06800	SPEECH PATHOLOGY	0	144,593	68.00
69.00	06900	ELECTROCARDIOLOGY	0	163,608	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	161,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	127,972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	717,883	73.00
76.00	03020	SLEEP LAB	0	142,125	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	303,685	90.00
91.00	09100	EMERGENCY	0	3,590,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	322,493	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,094,526	26,608,125	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	-7,839	106,253	194.01
194.02	07952	SENIOR CIRCLE	0	0	194.02
194.03	07953	FREE MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-6,102,365	26,714,378	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	1,439,200	1.00
	TOTALS		0	1,439,200	
<b>B - OXYGEN COSTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32,663	1.00
	TOTALS		0	32,663	
<b>C - RENTAL AND LEASE</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	432,473	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	432,473	
<b>D - OTHER CAPITAL</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	60,386	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	318,392	2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	22,952	3.00
	TOTALS		0	401,730	
<b>E - MARKETING DEPARTMENT</b>					
1.00	MARKETING	194.01	50,784	63,308	1.00
2.00	SENIOR CIRCLE	194.02	0	2,553	2.00
	TOTALS		50,784	65,861	
<b>F - CNO</b>					
1.00	NURSING ADMINISTRATION	13.00	171,539	0	1.00
	TOTALS		171,539	0	
<b>G - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	129,100	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	127,972	2.00
	TOTALS		0	257,072	
<b>H - DRUGS AND IV</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	717,883	1.00
	TOTALS		0	717,883	
<b>I - NURSERY</b>					
1.00	NURSERY	43.00	48,433	8,791	1.00
	TOTALS		48,433	8,791	
<b>J - QUALITY AND CASE MGT</b>					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	196,103	51,620	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	77,694	6,606	2.00
	TOTALS		273,797	58,226	
<b>K - FRAGMENTED A&amp;G</b>					
1.00	ADMINISTRATION	5.01	599,063	5,753,858	1.00
	TOTALS		599,063	5,753,858	
<b>L - RADIOLOGY</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	259,456	402,365	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00

Provider CCN: 151318

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

Worksheet A-6  
Date/Time Prepared:  
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		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
		TOTALS		259,456	402,365	
		M - DIETARY				
1.00		CAFETERIA	11.00	97,732	87,961	1.00
		TOTALS		97,732	87,961	
		N - PHYSICIAN PRACTICE				
1.00		OPERATION OF PLANT	7.00	373	9,449	1.00
		TOTALS		373	9,449	
500.00		Grand Total: Increases		1,501,177	9,667,532	500.00

RECLASSIFICATIONS

Provider CCN: 151318

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2013 4:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - EMPLOYEE BENEFITS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	1,439,200	0		1.00
	TOTALS		0	1,439,200			
<b>B - OXYGEN COSTS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,663	0		1.00
	TOTALS		0	32,663			
<b>C - RENTAL AND LEASE</b>							
1.00	EMPLOYEE BENEFITS	4.00	0	1,522	11		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	26,079	0		2.00
3.00	OPERATION OF PLANT	7.00	0	7,675	0		3.00
4.00	DIETARY	10.00	0	1,265	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	4,478	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,965	0		6.00
7.00	PHARMACY	15.00	0	78,036	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,148	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	10,359	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,225	0		10.00
11.00	OPERATING ROOM	50.00	0	67,691	0		11.00
12.00	RECOVERY ROOM	51.00	0	93	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	81,772	0		13.00
14.00	CT SCAN	57.00	0	63,732	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	625	0		15.00
16.00	LABORATORY	60.00	0	66,234	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	1,007	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	926	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,105	0		19.00
20.00	SLEEP LAB	76.00	0	2,677	0		20.00
21.00	CLINIC	90.00	0	3,043	0		21.00
22.00	EMERGENCY	91.00	0	3,220	0		22.00
23.00	AMBULANCE SERVICES	95.00	0	3,538	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	58	0		24.00
	TOTALS		0	432,473			
<b>D - OTHER CAPITAL</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	401,730	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	401,730			
<b>E - MARKETING DEPARTMENT</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	50,784	65,861	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		50,784	65,861			
<b>F - CNO</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	171,539	0	0		1.00
	TOTALS		171,539	0			
<b>G - MEDICAL SUPPLIES</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	195,157	0		1.00
2.00	OPERATING ROOM	50.00	0	61,915	0		2.00
	TOTALS		0	257,072			
<b>H - DRUGS AND IV</b>							
1.00	PHARMACY	15.00	0	717,883	0		1.00
	TOTALS		0	717,883			
<b>I - NURSERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	48,433	8,791	0		1.00
	TOTALS		48,433	8,791			
<b>J - QUALITY AND CASE MGT</b>							
1.00	NURSING ADMINISTRATION	13.00	273,797	58,226	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		273,797	58,226			
<b>K - FRAGMENTED A&amp;G</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	599,063	5,753,858	0		1.00
	TOTALS		599,063	5,753,858			
<b>L - RADIOLOGY</b>							
1.00	ULTRASOUND	54.01	106,479	15,601	0		1.00
2.00	RADIOISOTOPE	56.00	67,829	147,295	0		2.00
3.00	CT SCAN	57.00	42,735	137,780	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	42,413	101,689	0		4.00

Provider CCN: 151318

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

Worksheet A-6  
Date/Time Prepared:  
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
TOTALS		259,456	402,365			
M - DIETARY						
1.00	10.00	97,732	87,961	0		1.00
TOTALS		97,732	87,961			
N - PHYSICIAN PRACTICE						
1.00	192.00	373	9,449	0		1.00
TOTALS		373	9,449			
500.00	Grand Total: Decreases		1,501,177	9,667,532		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151318

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/30/2013 4:28 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	193,225	0	0	0	1.00
2.00	Land Improvements	853,039	121,405	0	121,405	2.00
3.00	Buildings and Fixtures	19,873,209	0	0	9,723	3.00
4.00	Building Improvements	3,559,068	2,141,182	0	2,141,182	4.00
5.00	Fixed Equipment	1,770,279	231,545	0	231,545	5.00
6.00	Movable Equipment	14,885,080	3,183,289	0	3,183,289	6.00
7.00	HIT designated Assets	0	2,038,462	0	2,038,462	7.00
8.00	Subtotal (sum of lines 1-7)	41,133,900	7,715,883	0	7,715,883	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,133,900	7,715,883	0	7,715,883	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	601,436	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,452,720	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,054,156	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	601,436	0	601,436	0.292790	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,452,720	0	1,452,720	0.707210	2.00
3.00	Total (sum of lines 1-2)	2,054,156	0	2,054,156	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151318

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	193,225	0			1.00	
2.00	Land Improvements	974,444	0			2.00	
3.00	Buildings and Fixtures	19,863,486	0			3.00	
4.00	Building Improvements	5,700,250	0			4.00	
5.00	Fixed Equipment	2,001,824	0			5.00	
6.00	Movable Equipment	17,939,161	0			6.00	
7.00	HIT designated Assets	2,038,462	0			7.00	
8.00	Subtotal (sum of lines 1-7)	48,710,852	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	48,710,852	0			10.00	
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	601,436			1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,452,720			2.00	
3.00	Total (sum of lines 1-2)	0	2,054,156			3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	931,355	-20,813	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,398,253	1,206	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,329,608	-19,607	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet A-7 Parts I-III Date/Time Prepared: 5/30/2013 4:28 pm
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	18,093	60,386	319,062	0	1,308,083	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	510,051	22,952	0	0	1,932,462	2.00
3.00	Total (sum of lines 1-2)	528,144	83,338	319,062	0	3,240,545	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151318

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

Worksheet A-8

Date/Time Prepared:  
5/30/2013 4:28 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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00
3.00 Investment income - other (chapter 2)		0			0.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00
8.00 Television and radio service (chapter 21)		0			0.00
9.00 Parking lot (chapter 21)		0			0.00
10.00 Provider-based physician adjustment	A-8-2	-793,150			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00
12.00 Related organization transactions (chapter 10)	A-8-1	-239,016			12.00
13.00 Laundry and linen service		0			0.00
14.00 Cafeteria-employees and guests	B	-68,882	CAFETERIA		11.00
15.00 Rental of quarters to employee and others		0			0.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00
17.00 Sale of drugs to other than patients		0			0.00
18.00 Sale of medical records and abstracts	B	-10,591	MEDICAL RECORDS & LIBRARY		16.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00
20.00 Vending machines	B	-2,617	OTHER ADMINISTRATIVE AND GENERAL		5.02
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***		114.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	A	329,919	NEW CAP REL COSTS-BLDG & FIXT		1.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	129,065	NEW CAP REL COSTS-MVBLE EQUIP		2.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***		19.00
29.00 Physicians' assistant		0			0.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY		68.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-178,698	NEW CAP REL COSTS-MVBLE EQUIP		2.00
33.00 SILVER RECOVERY	B	-1,706	RADIOLOGY-DIAGNOSTIC		54.00
35.00 TRAINING REVENUE	B	-3,255	NURSING ADMINISTRATION		13.00
36.00 FITNESS REVENUE	B	-240	OTHER ADMINISTRATIVE AND GENERAL		5.02
37.00 OTHER MISC REVENUE - HOSPITAL	B	-18,497	OTHER ADMINISTRATIVE AND GENERAL		5.02
38.00 HOSPITAL BAD DEBT	A	-5,072,340	ADMINISTRATIVE AND GENERAL		5.01
40.00 PATIENT PHONES WAGE COST	A	-7,570	OTHER ADMINISTRATIVE AND GENERAL		5.02
41.00 PATIENT PHONES BENEFITS COST	A	-1,502	EMPLOYEE BENEFITS		4.00
42.00 PATIENT PHONES EXPENSE	A	-1,341	OTHER ADMINISTRATIVE AND GENERAL		5.02
43.00 PATIENT PHONES DEPRECIATION COST	A	-4,744	NEW CAP REL COSTS-MVBLE EQUIP		2.00
44.00 PATIENT TV SERVICE COST	A	-19,271	OTHER ADMINISTRATIVE AND GENERAL		5.02
44.01 PATIENT TV DEPRECIATION	A	-90	NEW CAP REL COSTS-MVBLE EQUIP		2.00
45.00 MARKETING EXPENSE	A	-78,038	OTHER ADMINISTRATIVE AND GENERAL		5.02

Provider CCN: 151318      Period: From 01/01/2012 To 12/31/2012      Worksheet A-8  
 Date/Time Prepared: 5/30/2013 4:28 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	
			Cost Center			
			1.00	2.00		
45.01 PENALTIES	A	-1,060	OTHER ADMINISTRATIVE AND GENERAL	5.02	45.01	
45.02 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-1,586	OTHER ADMINISTRATIVE AND GENERAL	5.02	45.02	
45.03 CHARITABLE CONTRIBUTIONS	A	-15,319	OTHER ADMINISTRATIVE AND GENERAL	5.02	45.03	
45.04 LEGAL FEES	A	-29,663	OTHER ADMINISTRATIVE AND GENERAL	5.02	45.04	
45.05 PHYSICIAN RECRUITING	A	-19,845	OTHER ADMINISTRATIVE AND GENERAL	5.02	45.05	
45.06 POB UTILITIES	A	26,895	OPERATION OF PLANT	7.00	45.06	
45.07 POB COPIER LEASE	A	1,017	NEW CAP REL COSTS-MVBLE EQUIP	2.00	45.07	
45.08 POB PROPERTY TAX	A	670	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.08	
45.09 MEDICAL STAFF RELATIONS	A	-97	OTHER ADMINISTRATIVE AND GENERAL	5.02	45.09	
45.10 RENTAL INCOME	B	-20,813	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.10	
45.12		0		0.00	45.12	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,102,365			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 151318

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

Worksheet A-8

Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	9	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	9	27.00
28.00 Non-physician Anesthetist		28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00 SILVER RECOVERY	0	33.00
35.00 TRAINING REVENUE	0	35.00
36.00 FITNESS REVENUE	0	36.00
37.00 OTHER MISC REVENUE - HOSPITAL	0	37.00
38.00 HOSPITAL BAD DEBT	0	38.00
40.00 PATIENT PHONES WAGE COST	0	40.00
41.00 PATIENT PHONES BENEFITS COST	0	41.00
42.00 PATIENT PHONES EXPENSE	0	42.00
43.00 PATIENT PHONES DEPRECIATION COST	9	43.00
44.00 PATIENT TV SERVICE COST	0	44.00
44.01 PATIENT TV DEPRECIATION	9	44.01
45.00 MARKETING EXPENSE	0	45.00
45.01 PENALTIES	0	45.01
45.02 LOBBYING EXPENSE IN ASSOCIATION DUES	0	45.02
45.03 CHARITABLE CONTRIBUTIONS	0	45.03
45.04 LEGAL FEES	0	45.04
45.05 PHYSICIAN RECRUITING	0	45.05
45.06 POB UTILITIES	0	45.06
45.07 POB COPIER LEASE	10	45.07
45.08 POB PROPERTY TAX	13	45.08
45.09 MEDICAL STAFF RELATIONS	0	45.09
45.10 RENTAL INCOME	10	45.10
45.12	0	45.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 151318

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2013 4:28 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG & FIXTURES	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABLE EQUIP.	2.00
3.00	5.01	ADMIN TTING	PASI OPERATING COSTS	3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIXTURES	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPMENT	4.01
4.02	5.02	OTHER ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COSTS	4.02
4.03	5.02	OTHER ADMINISTRATIVE AND GENERAL	MALPRACTICE	4.03
4.05	2.00	NEW CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	4.05
4.06	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	4.06
4.07	5.02	OTHER ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	4.07
4.08	5.02	OTHER ADMINISTRATIVE AND GENERAL	401K FEES	4.08
4.09	5.02	OTHER ADMINISTRATIVE AND GENERAL	AUDIT FEES	4.09
4.10	5.02	OTHER ADMINISTRATIVE AND GENERAL	MIS FEES	4.10
4.11	5.02	OTHER ADMINISTRATIVE AND GENERAL	MANAGED CARE	4.11
4.12	5.02	OTHER ADMINISTRATIVE AND GENERAL	CASE MANAGEMENT	4.12
4.13	5.02	OTHER ADMINISTRATIVE AND GENERAL	PURCHASE & ANCILLARY	4.13
4.14	5.02	OTHER ADMINISTRATIVE AND GENERAL	EMERGENCY ROOM	4.14
4.15	5.02	OTHER ADMINISTRATIVE AND GENERAL	PBS FEES	4.15
4.16	5.02	OTHER ADMINISTRATIVE AND GENERAL	COMPLIANCE/HIM/CCA FEES	4.16
4.17	194.01	MARKETING	SENIOR CIRCLE	4.17
4.18	5.01	ADMIN TTING	PASI COLLECTION FEES	4.18
4.19	5.01	ADMIN TTING	PASI COLLECTION FEES	4.19
4.20	5.01	ADMIN TTING	PASI LIEN UNIT COLLECTION FEES	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

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

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

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

6.00		B		0.00	6.00
7.00		G		0.00	7.00
8.00		G		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:		RELATED CORP		100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-1 Date/Time Prepared: 5/30/2013 4:28 pm
	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

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

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

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

Provider CCN: 151318

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2013 4:28 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5,134	0	5,134	11	1.00
2.00	2,563	0	2,563	11	2.00
3.00	92,038	0	92,038	0	3.00
4.00	12,959	0	12,959	11	4.00
4.01	75,015	0	75,015	11	4.01
4.02	616,935	0	616,935	0	4.02
4.03	72,384	410,992	-338,608	0	4.03
4.05	57,220	57,031	189	10	4.05
4.06	113,137	96,957	16,180	0	4.06
4.07	0	286,910	-286,910	0	4.07
4.08	0	1,005	-1,005	0	4.08
4.09	0	19,926	-19,926	0	4.09
4.10	0	148,450	-148,450	0	4.10
4.11	0	10,288	-10,288	0	4.11
4.12	0	38,354	-38,354	0	4.12
4.13	0	3,383	-3,383	0	4.13
4.14	0	18,440	-18,440	0	4.14
4.15	0	14,350	-14,350	0	4.15
4.16	0	10,963	-10,963	0	4.16
4.17	0	7,839	-7,839	0	4.17
4.18	0	62,833	-62,833	0	4.18
4.19	0	81,492	-81,492	0	4.19
4.20	0	17,188	-17,188	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,047,385	1,286,401	-239,016	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00	COMMUNITY HEALTH SYSTEMS	100.00	HOSPITAL MANAGEMENT	6.00
7.00	PASI	0.00	DEBT COLLECTION	7.00
8.00	HOSPITAL LAUNDRY SERVICE	0.00	LAUNDRY SERVICE	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: 151318

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2013 4:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	15,475	640	1.00
2.00	30.00	ADULTS & PEDIATRICS	368,000	368,000	2.00
3.00	50.00	OPERATING ROOM	424,510	424,510	3.00
4.00	60.00	LABORATORY	96,000	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	2,513	0	5.00
6.00	91.00	EMERGENCY	869,354	0	6.00
7.00	91.00	EMERGENCY	1,107,832	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			2,883,684	793,150	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151318

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2013 4:28 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	14,835	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	96,000	0	0	0	0	4.00
5.00	2,513	0	0	0	0	5.00
6.00	869,354	0	0	0	0	6.00
7.00	1,107,832	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	2,090,534					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151318

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2013 4:28 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	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: 151318

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2013 4:28 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	640	1.00
2.00	0	368,000	2.00
3.00	0	424,510	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	793,150	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 4:28 pm				
			Physical Therapy	Cost				
			1.00					
<b>PART I - GENERAL INFORMATION</b>								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00	
7.00	Standard travel expense rate					0.00	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	3,599.81	3,940.12	2,223.16	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	73.69	55.26	16.58	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.85	36.85	27.63			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
			1.00					
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					265,270	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					217,731	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					483,001	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					36,860	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					519,861	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00	
23.00	Total salary equivalency (see instructions)					519,861	23.00	
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>								
<b>Standard Travel Allowance</b>								
24.00	Therapists (line 3 times column 2, line 11)					0	24.00	
25.00	Assistants (line 4 times column 3, line 11)					0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>								
<b>Standard Travel Expense</b>								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151318				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 4:28 pm		
						Physical Therapy		Cost		
								1.00		
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00		
						Therapists	Assistants	Aides	Trainees	Total
						1.00	2.00	3.00	4.00	5.00
<b>PART V - OVERTIME COMPUTATION</b>										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	33.76	4.55	3.20	0.00	41.51	47.00			
48.00	Overtime rate (see instructions)	110.54	82.89	24.87	0.00		48.00			
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	3,731.83	377.15	79.58	0.00		49.00			
<b>CALCULATION OF LIMIT</b>										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	81.33	10.96	7.71	0.00	100.00	50.00			
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	81.33	10.96	7.71	0.00	100.00	51.00			
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>										
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.69	55.26	16.58	0.00		52.00			
53.00	Overtime cost limitation (line 51 times line 52)	5,993	606	128	0		53.00			
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	3,732	377	80	0		54.00			
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	2,488	251	53	0		55.00			
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	1,244	126	27	0	1,397	56.00			
								1.00		
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>										
57.00	Salary equivalency amount (from line 23)					519,861	57.00			
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0	58.00			
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00			
60.00	Overtime allowance (from column 5, line 56)					1,397	60.00			
61.00	Equipment cost (see instructions)					0	61.00			
62.00	Supplies (see instructions)					0	62.00			
63.00	Total allowance (sum of lines 57-62)					521,258	63.00			
64.00	Total cost of outside supplier services (from your records)					442,983	64.00			
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00			
<b>LINE 33 CALCULATION</b>										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00			
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01			
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02			
<b>LINE 34 CALCULATION</b>										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00			
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01			
101.02	Line 34 = sum of lines 27 and 31					0	101.02			
<b>LINE 35 CALCULATION</b>										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00			
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01			
102.02	Line 35 = sum of lines 31 and 32					0	102.02			

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 4:28 pm	
				Occupational Therapy		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,043.43	65.68	2,223.16	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.85	52.39	15.72	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.93	34.93	26.20			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					212,584	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					3,441	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					216,025	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					34,948	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					250,973	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					250,973	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 4:28 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	3.20	0.00	3.20	47.00
48.00	Overtime rate (see instructions)	104.78	78.59	23.58	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	75.46	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	100.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	100.00	0.00	100.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.85	52.39	15.72	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	1,572	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	75	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	50	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	25	0	25	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					250,973	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					25	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					250,998	63.00
64.00	Total cost of outside supplier services (from your records)					217,159	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 4:28 pm		
			Speech Pathology	Cost		
					1.00	
<b>PART I - GENERAL INFORMATION</b>						
1.00	Total number of weeks worked (excluding aides) (see instructions)				52	1.00
2.00	Line 1 multiplied by 15 hours per week				780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)				0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)				0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)				0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)				0	6.00
7.00	Standard travel expense rate				0.00	7.00
8.00	Optional travel expense rate per mile				0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees
		1.00	2.00	3.00	4.00	5.00
9.00	Total hours worked	0.00	1,929.22	0.00	2,219.96	0.00
10.00	AHSEA (see instructions)	0.00	67.14	50.35	15.11	0.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.57	33.57	25.18		
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01
						1.00
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>						
14.00	Supervisors (column 1, line 9 times column 1, line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)				129,528	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)				0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)				129,528	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)				33,544	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)				0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)				163,072	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)				0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)				0	22.00
23.00	Total salary equivalency (see instructions)				163,072	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>						
<b>Standard Travel Allowance</b>						
24.00	Therapists (line 3 times column 2, line 11)				0	24.00
25.00	Assistants (line 4 times column 3, line 11)				0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)				0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)				0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)				0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)				0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)				0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)				0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)				0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)				0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)				0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)				0	35.00
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>						
<b>Standard Travel Expense</b>						
36.00	Therapists (line 5 times column 2, line 11)				0	36.00
37.00	Assistants (line 6 times column 3, line 11)				0	37.00
38.00	Subtotal (sum of lines 36 and 37)				0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)				0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)				0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)				0	41.00
42.00	Subtotal (sum of lines 40 and 41)				0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)				0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)				0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)				0	45.00

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						Speech Pathology		Cost	
								1.00	
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<b>PART V - OVERTIME COMPUTATION</b>									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	15.15	0.00	3.20	15.15		47.00	
48.00	Overtime rate (see instructions)	100.71	75.53	22.67	0.00			48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	1,144.28	0.00	0.00			49.00	
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	78.88	0.00	21.12	100.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	78.88	0.00	21.12	100.00		51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.14	50.35	15.11	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	3,972	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	1,144	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	763	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	381	0	0	381		56.00	
								1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)					163,072		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					381		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					163,453		63.00	
64.00	Total cost of outside supplier services (from your records)					142,793		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,308,083	1,308,083			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,932,462		1,932,462		2.00
4.00 00400	EMPLOYEE BENEFITS	1,570,578	9,231	13,693	1,593,502	4.00
5.01 00540	ADMITTING	1,211,106	14,045	20,834	86,734	1,332,719 5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	4,707,700	66,597	98,789	198,316	0 5.02
7.00 00700	OPERATION OF PLANT	1,250,632	387,091	574,209	32,587	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	113,953	15,197	22,543	0	0 8.00
9.00 00900	HOUSEKEEPING	316,100	12,582	18,663	36,631	0 9.00
10.00 01000	DIETARY	170,265	31,765	47,120	12,974	0 10.00
11.00 01100	CAFETERIA	116,811	20,402	30,264	14,150	0 11.00
13.00 01300	NURSING ADMINISTRATION	230,963	5,933	8,801	31,225	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	224,415	31,136	46,187	10,546	0 14.00
15.00 01500	PHARMACY	510,025	14,535	21,561	49,674	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	419,516	26,269	38,967	28,789	0 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,826,618	218,047	323,447	223,017	77,196 30.00
31.00 03100	INTENSIVE CARE UNIT	406,628	25,269	37,484	52,999	10,542 31.00
43.00 04300	NURSERY	57,224	5,000	7,416	7,012	4,712 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	684,919	100,177	148,600	53,588	151,031 50.00
51.00 05100	RECOVERY ROOM	221,120	7,211	10,697	27,868	27,242 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,282,197	70,457	104,515	111,404	256,788 54.00
54.01 05401	ULTRASOUND	0	0	0	0	0 54.01
56.00 05600	RADIO SOTOP	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00 06000	LABORATORY	1,327,209	28,170	41,786	88,387	193,529 60.00
65.00 06500	RESPIRATORY THERAPY	376,168	12,092	17,937	48,550	24,328 65.00
66.00 06600	PHYSICAL THERAPY	450,391	16,595	24,616	214	37,070 66.00
67.00 06700	OCCUPATIONAL THERAPY	218,185	5,430	8,055	0	15,014 67.00
68.00 06800	SPEECH PATHOLOGY	144,593	219	324	0	7,302 68.00
69.00 06900	ELECTROCARDIOLOGY	163,608	8,205	12,171	20,280	45,749 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	161,763	0	0	0	45,534 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	127,972	0	0	0	9,386 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	717,883	0	0	0	171,609 73.00
76.00 03020	SLEEP LAB	142,125	11,714	17,377	17,847	11,901 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	303,685	7,615	11,296	35,376	6,881 90.00
91.00 09100	EMERGENCY	3,590,735	48,526	71,982	368,728	184,977 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	322,493	19,541	28,987	29,253	51,928 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	26,608,125	1,219,051	1,808,321	1,586,149	1,332,719 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,344	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	83,688	124,141	0	0 192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	MARKETING	106,253	0	0	7,353	0 194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	0 194.02
194.03 07953	FREE MEALS	0	0	0	0	0 194.03
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	26,714,378	1,308,083	1,932,462	1,593,502	1,332,719 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet B  
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Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A. 01	5. 02	7. 00	8. 00	9. 00	
<b>GENERAL SERVICE COST CENTERS</b>							
1. 00	00100						1. 00
2. 00	00200						2. 00
4. 00	00400						4. 00
5. 01	00540						5. 01
5. 02	00560	5,071,402	5,071,402				5. 02
7. 00	00700	2,244,519	525,938	2,770,457			7. 00
8. 00	00800	151,693	35,545	50,659	237,897		8. 00
9. 00	00900	383,976	89,974	41,940	0	515,890	9. 00
10. 00	01000	262,124	61,421	105,887	0	20,399	10. 00
11. 00	01100	181,627	42,559	68,009	0	13,102	11. 00
13. 00	01300	276,922	64,889	19,778	0	3,810	13. 00
14. 00	01400	312,284	73,175	103,790	0	19,995	14. 00
15. 00	01500	595,795	139,607	48,452	0	9,334	15. 00
16. 00	01600	513,541	120,333	87,566	0	16,870	16. 00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30. 00	03000	2,668,325	625,245	726,841	94,441	140,026	30. 00
31. 00	03100	532,922	124,875	84,233	5,791	16,227	31. 00
43. 00	04300	81,364	19,065	16,666	0	3,211	43. 00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50. 00	05000	1,138,315	266,731	333,929	39,476	64,332	50. 00
51. 00	05100	294,138	68,923	24,038	0	4,631	51. 00
52. 00	05200	0	0	0	0	0	52. 00
53. 00	05300	0	0	0	0	0	53. 00
54. 00	05400	1,825,361	427,720	234,863	26,881	45,246	54. 00
54. 01	05401	0	0	0	0	0	54. 01
56. 00	05600	0	0	0	0	0	56. 00
57. 00	05700	0	0	0	0	0	57. 00
58. 00	05800	0	0	0	0	0	58. 00
60. 00	06000	1,679,081	393,444	93,901	390	18,090	60. 00
65. 00	06500	479,075	112,257	40,306	0	7,765	65. 00
66. 00	06600	528,886	123,929	55,316	0	10,657	66. 00
67. 00	06700	246,684	57,803	18,100	0	3,487	67. 00
68. 00	06800	152,438	35,719	728	0	140	68. 00
69. 00	06900	250,013	58,583	27,349	0	5,269	69. 00
71. 00	07100	207,297	48,574	0	0	0	71. 00
72. 00	07200	137,358	32,186	0	0	0	72. 00
73. 00	07300	889,492	208,427	0	0	0	73. 00
76. 00	03020	200,964	47,090	39,048	5,956	7,523	76. 00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90. 00	09000	364,853	85,493	25,385	0	4,890	90. 00
91. 00	09100	4,264,948	999,366	161,755	64,962	31,162	91. 00
92. 00	09200	0	0	0	0	0	92. 00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95. 00	09500	452,202	105,960	65,139	0	12,549	95. 00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118. 00		26,387,599	4,994,831	2,473,678	237,897	458,715	118. 00
<b>NONREIMBURSABLE COST CENTERS</b>							
190. 00	19000	5,344	1,252	17,813	0	3,432	190. 00
192. 00	19200	207,829	48,699	278,966	0	53,743	192. 00
194. 00	07950	0	0	0	0	0	194. 00
194. 01	07951	113,606	26,620	0	0	0	194. 01
194. 02	07952	0	0	0	0	0	194. 02
194. 03	07953	0	0	0	0	0	194. 03
200. 00		0	0	0	0	0	200. 00
201. 00		0	0	0	0	0	201. 00
202. 00		26,714,378	5,071,402	2,770,457	237,897	515,890	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet B  
Part I  
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	449,831					10.00
11.00	01100	0	305,297				11.00
13.00	01300	0	3,174	368,573			13.00
14.00	01400	0	5,104	0	514,348		14.00
15.00	01500	0	9,866	0	13,450	816,504	15.00
16.00	01600	0	12,139	0	1,020	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	303,661	62,711	129,237	36,563	0	30.00
31.00	03100	48,297	12,096	24,928	3,785	0	31.00
43.00	04300	0	1,673	3,447	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	14,777	30,453	69,703	0	50.00
51.00	05100	0	6,584	13,569	4,476	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	30,819	0	54,192	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	31,977	0	145,650	0	60.00
65.00	06500	0	12,975	0	5,377	0	65.00
66.00	06600	0	107	0	2,493	0	66.00
67.00	06700	0	0	0	347	0	67.00
68.00	06800	0	0	0	609	0	68.00
69.00	06900	0	5,383	0	1,653	0	69.00
71.00	07100	0	0	0	80,865	0	71.00
72.00	07200	0	0	0	43,554	0	72.00
73.00	07300	0	0	0	0	816,504	73.00
76.00	03020	0	4,890	0	2,488	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	7,828	0	13,136	0	90.00
91.00	09100	0	68,953	142,099	20,372	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	12,053	24,840	12,249	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		351,958	303,109	368,573	511,982	816,504	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	2,188	0	2,366	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	97,873	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		449,831	305,297	368,573	514,348	816,504	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151318

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.01	00540	ADMITTING				5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	751,469			16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	43,528	4,830,578	0	4,830,578	30.00
31.00	03100	INTENSIVE CARE UNIT	5,944	859,098	0	859,098	31.00
43.00	04300	NURSERY	2,657	128,083	0	128,083	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	85,160	2,042,876	0	2,042,876	50.00
51.00	05100	RECOVERY ROOM	15,361	431,720	0	431,720	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	144,799	2,789,881	0	2,789,881	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	109,122	2,471,655	0	2,471,655	60.00
65.00	06500	RESPIRATORY THERAPY	13,717	671,472	0	671,472	65.00
66.00	06600	PHYSICAL THERAPY	20,902	742,290	0	742,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,466	334,887	0	334,887	67.00
68.00	06800	SPEECH PATHOLOGY	4,117	193,751	0	193,751	68.00
69.00	06900	ELECTROCARDIOLOGY	25,796	374,046	0	374,046	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,674	362,410	0	362,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,292	218,390	0	218,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,763	2,011,186	0	2,011,186	73.00
76.00	03020	SLEEP LAB	6,711	314,670	0	314,670	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	3,880	505,465	0	505,465	90.00
91.00	09100	EMERGENCY	104,300	5,857,917	0	5,857,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	29,280	714,272	0	714,272	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	751,469	25,854,647	0	25,854,647	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,841	0	27,841	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	589,237	0	589,237	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	144,780	0	144,780	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	97,873	0	97,873	194.03
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	751,469	26,714,378	0	26,714,378	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151318

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

Worksheet B  
Part II  
Date/Time Prepared:  
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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			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	9,231	13,693	22,924	4.00
5.01 00540	ADMITTING	0	14,045	20,834	34,879	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	66,597	98,789	165,386	5.02
7.00 00700	OPERATION OF PLANT	0	387,091	574,209	961,300	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,197	22,543	37,740	8.00
9.00 00900	HOUSEKEEPING	0	12,582	18,663	31,245	9.00
10.00 01000	DIETARY	0	31,765	47,120	78,885	10.00
11.00 01100	CAFETERIA	0	20,402	30,264	50,666	11.00
13.00 01300	NURSING ADMINISTRATION	0	5,933	8,801	14,734	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	31,136	46,187	77,323	14.00
15.00 01500	PHARMACY	0	14,535	21,561	36,096	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	26,269	38,967	65,236	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	218,047	323,447	541,494	30.00
31.00 03100	INTENSIVE CARE UNIT	0	25,269	37,484	62,753	31.00
43.00 04300	NURSERY	0	5,000	7,416	12,416	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	100,177	148,600	248,777	50.00
51.00 05100	RECOVERY ROOM	0	7,211	10,697	17,908	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	70,457	104,515	174,972	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00 06000	LABORATORY	0	28,170	41,786	69,956	60.00
65.00 06500	RESPIRATORY THERAPY	0	12,092	17,937	30,029	65.00
66.00 06600	PHYSICAL THERAPY	0	16,595	24,616	41,211	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	5,430	8,055	13,485	67.00
68.00 06800	SPEECH PATHOLOGY	0	219	324	543	68.00
69.00 06900	ELECTROCARDIOLOGY	0	8,205	12,171	20,376	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	SLEEP LAB	0	11,714	17,377	29,091	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	7,615	11,296	18,911	90.00
91.00 09100	EMERGENCY	0	48,526	71,982	120,508	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	19,541	28,987	48,528	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,219,051	1,808,321	3,027,372	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,344	0	5,344	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	83,688	124,141	207,829	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	MARKETING	0	0	0	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03 07953	FREE MEALS	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,308,083	1,932,462	3,240,545	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		ADMINISTRATIVE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	5.02	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	36,127					5.01
5.02	00560	0	168,239				5.02
7.00	00700	0	17,447	979,216			7.00
8.00	00800	0	1,179	17,905	56,824		8.00
9.00	00900	0	2,985	14,824	0	49,581	9.00
10.00	01000	0	2,037	37,426	0	1,961	10.00
11.00	01100	0	1,412	24,038	0	1,259	11.00
13.00	01300	0	2,153	6,990	0	366	13.00
14.00	01400	0	2,427	36,685	0	1,922	14.00
15.00	01500	0	4,631	17,125	0	897	15.00
16.00	01600	0	3,992	30,950	0	1,621	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,091	20,741	256,902	22,558	13,457	30.00
31.00	03100	286	4,142	29,772	1,383	1,560	31.00
43.00	04300	128	632	5,890	0	309	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	4,091	8,848	118,027	9,429	6,183	50.00
51.00	05100	738	2,286	8,496	0	445	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	6,985	14,189	83,012	6,421	4,349	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	5,242	13,051	33,189	93	1,739	60.00
65.00	06500	659	3,724	14,246	0	746	65.00
66.00	06600	1,004	4,111	19,552	0	1,024	66.00
67.00	06700	407	1,917	6,398	0	335	67.00
68.00	06800	198	1,185	257	0	13	68.00
69.00	06900	1,239	1,943	9,667	0	506	69.00
71.00	07100	1,233	1,611	0	0	0	71.00
72.00	07200	254	1,068	0	0	0	72.00
73.00	07300	4,648	6,914	0	0	0	73.00
76.00	03020	322	1,562	13,802	1,423	723	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	186	2,836	8,972	0	470	90.00
91.00	09100	5,010	33,161	57,172	15,517	2,995	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	1,406	3,515	23,023	0	1,206	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00							
		36,127	165,699	874,320	56,824	44,086	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	42	6,296	0	330	190.00
192.00	19200	0	1,615	98,600	0	5,165	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	883	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		36,127	168,239	979,216	56,824	49,581	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	120,496					10.00
11.00	01100	0	77,579				11.00
13.00	01300	0	807	25,499			13.00
14.00	01400	0	1,297	0	119,806		14.00
15.00	01500	0	2,507	0	3,133	65,104	15.00
16.00	01600	0	3,085	0	238	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	81,342	15,935	8,941	8,517	0	30.00
31.00	03100	12,937	3,074	1,725	882	0	31.00
43.00	04300	0	425	239	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	3,755	2,107	16,236	0	50.00
51.00	05100	0	1,673	939	1,043	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	7,831	0	12,623	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	8,126	0	33,922	0	60.00
65.00	06500	0	3,297	0	1,253	0	65.00
66.00	06600	0	27	0	581	0	66.00
67.00	06700	0	0	0	81	0	67.00
68.00	06800	0	0	0	142	0	68.00
69.00	06900	0	1,368	0	385	0	69.00
71.00	07100	0	0	0	18,836	0	71.00
72.00	07200	0	0	0	10,145	0	72.00
73.00	07300	0	0	0	0	65,104	73.00
76.00	03020	0	1,243	0	580	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	1,989	0	3,060	0	90.00
91.00	09100	0	17,521	9,830	4,745	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	3,063	1,718	2,853	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		94,279	77,023	25,499	119,255	65,104	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	556	0	551	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	26,217	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		120,496	77,579	25,499	119,806	65,104	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151318

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.01	00540	ADMITTING				5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	105,536			16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	6,112	981,299	0	981,299	30.00
31.00	03100	INTENSIVE CARE UNIT	835	120,112	0	120,112	31.00
43.00	04300	NURSERY	373	20,513	0	20,513	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	11,958	430,182	0	430,182	50.00
51.00	05100	RECOVERY ROOM	2,157	36,086	0	36,086	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,351	332,336	0	332,336	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	15,322	181,912	0	181,912	60.00
65.00	06500	RESPIRATORY THERAPY	1,926	56,579	0	56,579	65.00
66.00	06600	PHYSICAL THERAPY	2,935	70,448	0	70,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,189	23,812	0	23,812	67.00
68.00	06800	SPEECH PATHOLOGY	578	2,916	0	2,916	68.00
69.00	06900	ELECTROCARDIOLOGY	3,622	39,398	0	39,398	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,605	25,285	0	25,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	743	12,210	0	12,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,587	90,253	0	90,253	73.00
76.00	03020	SLEEP LAB	942	49,945	0	49,945	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	545	37,478	0	37,478	90.00
91.00	09100	EMERGENCY	14,645	286,403	0	286,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	4,111	89,844	0	89,844	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	105,536	2,887,011	0	2,887,011	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,012	0	12,012	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	313,209	0	313,209	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,096	0	2,096	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	26,217	0	26,217	194.03
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	105,536	3,240,545	0	3,240,545	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151318

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation		
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	197,538					1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		196,731				2.00	
4.00 00400 EMPLOYEE BENEFITS	1,394	1,394	11,006,217			4.00	
5.01 00540 ADMITTING	2,121	2,121	599,063	102,841,584		5.01	
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL	10,057	10,057	1,369,757	0	-5,071,402	5.02	
7.00 00700 OPERATION OF PLANT	58,456	58,456	225,077	0	0	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	2,295	2,295	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	1,900	1,900	253,005	0	0	9.00	
10.00 01000 DIETARY	4,797	4,797	89,612	0	0	10.00	
11.00 01100 CAFETERIA	3,081	3,081	97,732	0	0	11.00	
13.00 01300 NURSING ADMINISTRATION	896	896	215,666	0	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	4,702	4,702	72,843	0	0	14.00	
15.00 01500 PHARMACY	2,195	2,195	343,098	0	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	3,967	3,967	198,842	0	0	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	32,928	32,928	1,540,366	5,956,978		30.00	
31.00 03100 INTENSIVE CARE UNIT	3,816	3,816	366,061	813,467		31.00	
43.00 04300 NURSERY	755	755	48,433	363,625		43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	15,128	15,128	370,126	11,654,527		50.00	
51.00 05100 RECOVERY ROOM	1,089	1,089	192,481	2,102,186		51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0		53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	10,640	10,640	769,458	19,815,888		54.00	
54.01 05401 ULTRASOUND	0	0	0	0		54.01	
56.00 05600 RADIOISOTOPE	0	0	0	0		56.00	
57.00 05700 CT SCAN	0	0	0	0		57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00	
60.00 06000 LABORATORY	4,254	4,254	610,486	14,933,927		60.00	
65.00 06500 RESPIRATORY THERAPY	1,826	1,826	335,335	1,877,292		65.00	
66.00 06600 PHYSICAL THERAPY	2,506	2,506	1,479	2,860,524		66.00	
67.00 06700 OCCUPATIONAL THERAPY	820	820	0	1,158,597		67.00	
68.00 06800 SPEECH PATHOLOGY	33	33	0	563,431		68.00	
69.00 06900 ELECTROCARDIOLOGY	1,239	1,239	140,075	3,530,266		69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,513,661		71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	724,282		72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	13,242,482		73.00	
76.00 03020 SLEEP LAB	1,769	1,769	123,267	918,376		76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	1,150	1,150	244,341	531,002		90.00	
91.00 09100 EMERGENCY	7,328	7,328	2,546,779	14,274,010		91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500 AMBULANCE SERVICES	2,951	2,951	202,051	4,007,063		95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	184,093	184,093	10,955,433	102,841,584	-5,071,402	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	0	0	0		190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	12,638	12,638	0	0		192.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00	
194.01 07951 MARKETING	0	0	50,784	0		194.01	
194.02 07952 SENIOR CIRCLE	0	0	0	0		194.02	
194.03 07953 FREE MEALS	0	0	0	0		194.03	
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)	1,308,083	1,932,462	1,593,502	1,332,719	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	6.621931	9.822865	0.144782	0.012959	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			22,924	36,127	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002083	0.000351	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151318

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.02	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00540	ADMINISTRATIVE					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	21,642,976				5.02
7.00	00700	OPERATION OF PLANT	2,244,519	125,510			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	151,693	2,295	182,609		8.00
9.00	00900	HOUSEKEEPING	383,976	1,900	0	121,315	9.00
10.00	01000	DIETARY	262,124	4,797	0	4,797	19,708
11.00	01100	CAFETERIA	181,627	3,081	0	3,081	0
13.00	01300	NURSING ADMINISTRATION	276,922	896	0	896	0
14.00	01400	CENTRAL SERVICES & SUPPLY	312,284	4,702	0	4,702	0
15.00	01500	PHARMACY	595,795	2,195	0	2,195	0
16.00	01600	MEDICAL RECORDS & LIBRARY	513,541	3,967	0	3,967	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,668,325	32,928	72,492	32,928	13,304
31.00	03100	INTENSIVE CARE UNIT	532,922	3,816	4,445	3,816	2,116
43.00	04300	NURSERY	81,364	755	0	755	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,138,315	15,128	30,302	15,128	0
51.00	05100	RECOVERY ROOM	294,138	1,089	0	1,089	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,825,361	10,640	20,634	10,640	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	1,679,081	4,254	299	4,254	0
65.00	06500	RESPIRATORY THERAPY	479,075	1,826	0	1,826	0
66.00	06600	PHYSICAL THERAPY	528,886	2,506	0	2,506	0
67.00	06700	OCCUPATIONAL THERAPY	246,684	820	0	820	0
68.00	06800	SPEECH PATHOLOGY	152,438	33	0	33	0
69.00	06900	ELECTROCARDIOLOGY	250,013	1,239	0	1,239	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	207,297	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	137,358	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	889,492	0	0	0	0
76.00	03020	SLEEP LAB	200,964	1,769	4,572	1,769	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	364,853	1,150	0	1,150	0
91.00	09100	EMERGENCY	4,264,948	7,328	49,865	7,328	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	452,202	2,951	0	2,951	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,316,197	112,065	182,609	107,870	15,420
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,344	807	0	807	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	207,829	12,638	0	12,638	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	MARKETING	113,606	0	0	0	0
194.02	07952	SENIOR CIRCLE	0	0	0	0	0
194.03	07953	FREE MEALS	0	0	0	0	4,288
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)	5,071,402	2,770,457	237,897	515,890	449,831
203.00		Unit cost multiplier (Wkst. B, Part I)	0.234321	22.073596	1.302767	4.252483	22.824792
204.00		Cost to be allocated (per Wkst. B, Part II)	168,239	979,216	56,824	49,581	120,496
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007773	7.801896	0.311179	0.408696	6.114065

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151318

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

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Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES NURS AREAS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00540 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
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	14,235					11.00
13.00	01300 NURSING ADMINISTRATION	148	8,339				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	238	0	1,519,284			14.00
15.00	01500 PHARMACY	460	0	39,730	717,883		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	566	0	3,012	0	102,841,584	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,924	2,924	108,001	0	5,956,978	30.00
31.00	03100 INTENSIVE CARE UNIT	564	564	11,180	0	813,467	31.00
43.00	04300 NURSERY	78	78	0	0	363,625	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	689	689	205,889	0	11,654,527	50.00
51.00	05100 RECOVERY ROOM	307	307	13,221	0	2,102,186	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,437	0	160,072	0	19,815,888	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	1,491	0	430,218	0	14,933,927	60.00
65.00	06500 RESPIRATORY THERAPY	605	0	15,884	0	1,877,292	65.00
66.00	06600 PHYSICAL THERAPY	5	0	7,365	0	2,860,524	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	1,026	0	1,158,597	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1,800	0	563,431	68.00
69.00	06900 ELECTROCARDIOLOGY	251	0	4,883	0	3,530,266	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	238,859	0	3,513,661	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	128,649	0	724,282	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	717,883	13,242,482	73.00
76.00	03020 SLEEP LAB	228	0	7,349	0	918,376	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	365	0	38,802	0	531,002	90.00
91.00	09100 EMERGENCY	3,215	3,215	60,174	0	14,274,010	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	562	562	36,180	0	4,007,063	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,133	8,339	1,512,294	717,883	102,841,584	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MARKETING	102	0	6,990	0	0	194.01
194.02	07952 SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953 FREE MEALS	0	0	0	0	0	194.03
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)	305,297	368,573	514,348	816,504	751,469	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.446927	44.198705	0.338546	1.137378	0.007307	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	77,579	25,499	119,806	65,104	105,536	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.449877	3.057801	0.078857	0.090689	0.001026	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
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		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		4,830,578	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		859,098	0	0	31.00
43.00	04300 NURSERY		128,083	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,042,876	0	0	50.00
51.00	05100 RECOVERY ROOM		431,720	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,789,881	0	0	54.00
54.01	05401 ULTRASOUND		0	0	0	54.01
56.00	05600 RADIOISOTOPE		0	0	0	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
60.00	06000 LABORATORY		2,471,655	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	671,472	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	742,290	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	334,887	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	193,751	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		374,046	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		362,410	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		218,390	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,011,186	0	0	73.00
76.00	03020 SLEEP LAB		314,670	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		505,465	0	0	90.00
91.00	09100 EMERGENCY		5,857,917	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		954,335	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		714,272	0	0	95.00
200.00	Subtotal (see instructions)	0	26,808,982	0	0	200.00
201.00	Less Observation Beds		954,335			201.00
202.00	Total (see instructions)	0	25,854,647	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	4,654,497		4,654,497			30.00
31.00 03100 INTENSIVE CARE UNIT	813,467		813,467			31.00
43.00 04300 NURSERY	363,625		363,625			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	2,712,558	8,941,969	11,654,527	0.175286	0.000000	50.00
51.00 05100 RECOVERY ROOM	391,659	1,710,527	2,102,186	0.205367	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,178,263	17,637,625	19,815,888	0.140790	0.000000	54.00
54.01 05401 ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00 06000 LABORATORY	3,151,408	11,782,519	14,933,927	0.165506	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	1,442,899	434,393	1,877,292	0.357681	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	576,691	2,283,833	2,860,524	0.259494	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	548,118	610,479	1,158,597	0.289045	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	69,116	494,315	563,431	0.343877	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	908,723	2,621,543	3,530,266	0.105954	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,443,317	2,070,344	3,513,661	0.103143	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	79,467	644,815	724,282	0.301526	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6,649,761	6,592,721	13,242,482	0.151874	0.000000	73.00
76.00 03020 SLEEP LAB	22,242	896,134	918,376	0.342637	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	6,829	524,173	531,002	0.951908	0.000000	90.00
91.00 09100 EMERGENCY	610,477	13,663,533	14,274,010	0.410390	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9,484	1,292,997	1,302,481	0.732706	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	4,007,063	4,007,063	0.178253	0.000000	95.00
200.00	Subtotal (see instructions)	26,632,601	76,208,983	102,841,584		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	26,632,601	76,208,983	102,841,584		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 SLEEP LAB	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
Date/Time Prepared:  
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		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,830,578		4,830,578	0	4,830,578	30.00
31.00	03100 INTENSIVE CARE UNIT	859,098		859,098	0	859,098	31.00
43.00	04300 NURSERY	128,083		128,083	0	128,083	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,042,876		2,042,876	0	2,042,876	50.00
51.00	05100 RECOVERY ROOM	431,720		431,720	0	431,720	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,789,881		2,789,881	0	2,789,881	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
56.00	05600 RADIOISOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000 LABORATORY	2,471,655		2,471,655	0	2,471,655	60.00
65.00	06500 RESPIRATORY THERAPY	671,472	0	671,472	0	671,472	65.00
66.00	06600 PHYSICAL THERAPY	742,290	0	742,290	0	742,290	66.00
67.00	06700 OCCUPATIONAL THERAPY	334,887	0	334,887	0	334,887	67.00
68.00	06800 SPEECH PATHOLOGY	193,751	0	193,751	0	193,751	68.00
69.00	06900 ELECTROCARDIOLOGY	374,046		374,046	0	374,046	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	362,410		362,410	0	362,410	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,390		218,390	0	218,390	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,011,186		2,011,186	0	2,011,186	73.00
76.00	03020 SLEEP LAB	314,670		314,670	0	314,670	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	505,465		505,465	0	505,465	90.00
91.00	09100 EMERGENCY	5,857,917		5,857,917	0	5,857,917	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	954,335		954,335	0	954,335	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	714,272		714,272	0	714,272	95.00
200.00	Subtotal (see instructions)	26,808,982	0	26,808,982	0	26,808,982	200.00
201.00	Less Observation Beds	954,335		954,335		954,335	201.00
202.00	Total (see instructions)	25,854,647	0	25,854,647	0	25,854,647	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151318

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 pm

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	4,654,497		4,654,497		30.00
31.00	03100	INTENSIVE CARE UNIT	813,467		813,467		31.00
43.00	04300	NURSERY	363,625		363,625		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,712,558	8,941,969	11,654,527	0.175286	50.00
51.00	05100	RECOVERY ROOM	391,659	1,710,527	2,102,186	0.205367	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,178,263	17,637,625	19,815,888	0.140790	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	3,151,408	11,782,519	14,933,927	0.165506	60.00
65.00	06500	RESPIRATORY THERAPY	1,442,899	434,393	1,877,292	0.357681	65.00
66.00	06600	PHYSICAL THERAPY	576,691	2,283,833	2,860,524	0.259494	66.00
67.00	06700	OCCUPATIONAL THERAPY	548,118	610,479	1,158,597	0.289045	67.00
68.00	06800	SPEECH PATHOLOGY	69,116	494,315	563,431	0.343877	68.00
69.00	06900	ELECTROCARDIOLOGY	908,723	2,621,543	3,530,266	0.105954	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,443,317	2,070,344	3,513,661	0.103143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	79,467	644,815	724,282	0.301526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,649,761	6,592,721	13,242,482	0.151874	73.00
76.00	03020	SLEEP LAB	22,242	896,134	918,376	0.342637	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	6,829	524,173	531,002	0.951908	90.00
91.00	09100	EMERGENCY	610,477	13,663,533	14,274,010	0.410390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,484	1,292,997	1,302,481	0.732706	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	4,007,063	4,007,063	0.178253	95.00
200.00		Subtotal (see instructions)	26,632,601	76,208,983	102,841,584		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	26,632,601	76,208,983	102,841,584		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/30/2013 4:28 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.175286		50.00
51.00	05100 RECOVERY ROOM	0.205367		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140790		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.165506		60.00
65.00	06500 RESPIRATORY THERAPY	0.357681		65.00
66.00	06600 PHYSICAL THERAPY	0.259494		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289045		67.00
68.00	06800 SPEECH PATHOLOGY	0.343877		68.00
69.00	06900 ELECTROCARDIOLOGY	0.105954		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.301526		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151874		73.00
76.00	03020 SLEEP LAB	0.342637		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.951908		90.00
91.00	09100 EMERGENCY	0.410390		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732706		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.178253		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151318

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

Worksheet C Part II Date/Time Prepared: 5/30/2013 4:28 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,042,876	430,182	1,612,694	0	0	50.00
51.00	05100 RECOVERY ROOM	431,720	36,086	395,634	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,789,881	332,336	2,457,545	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	2,471,655	181,912	2,289,743	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	671,472	56,579	614,893	0	0	65.00
66.00	06600 PHYSICAL THERAPY	742,290	70,448	671,842	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	334,887	23,812	311,075	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	193,751	2,916	190,835	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	374,046	39,398	334,648	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	362,410	25,285	337,125	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,390	12,210	206,180	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,011,186	90,253	1,920,933	0	0	73.00
76.00	03020 SLEEP LAB	314,670	49,945	264,725	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	505,465	37,478	467,987	0	0	90.00
91.00	09100 EMERGENCY	5,857,917	286,403	5,571,514	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	954,335	0	954,335	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	714,272	89,844	624,428	0	0	95.00
200.00	Subtotal (sum of lines 50 thru 199)	20,991,223	1,765,087	19,226,136	0	0	200.00
201.00	Less Observation Beds	954,335	0	954,335	0	0	201.00
202.00	Total (line 200 minus line 201)	20,036,888	1,765,087	18,271,801	0	0	202.00

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

Provider CCN: 151318

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

Worksheet C Part II Date/Time Prepared: 5/30/2013 4:28 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2,042,876	11,654,527	0.175286	50.00
51.00	05100 RECOVERY ROOM	431,720	2,102,186	0.205367	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,789,881	19,815,888	0.140790	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700 CT SCAN	0	0	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
60.00	06000 LABORATORY	2,471,655	14,933,927	0.165506	60.00
65.00	06500 RESPIRATORY THERAPY	671,472	1,877,292	0.357681	65.00
66.00	06600 PHYSICAL THERAPY	742,290	2,860,524	0.259494	66.00
67.00	06700 OCCUPATIONAL THERAPY	334,887	1,158,597	0.289045	67.00
68.00	06800 SPEECH PATHOLOGY	193,751	563,431	0.343877	68.00
69.00	06900 ELECTROCARDIOLOGY	374,046	3,530,266	0.105954	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	362,410	3,513,661	0.103143	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,390	724,282	0.301526	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,011,186	13,242,482	0.151874	73.00
76.00	03020 SLEEP LAB	314,670	918,376	0.342637	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	505,465	531,002	0.951908	90.00
91.00	09100 EMERGENCY	5,857,917	14,274,010	0.410390	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	954,335	1,302,481	0.732706	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	714,272	4,007,063	0.178253	95.00
200.00	Subtotal (sum of lines 50 thru 199)	20,991,223	97,009,995		200.00
201.00	Less Observation Beds	954,335	0		201.00
202.00	Total (line 200 minus line 201)	20,036,888	97,009,995		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151318

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/30/2013 4:28 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	430,182	11,654,527	0.036911	588,938	21,738	50.00	
51.00	05100	RECOVERY ROOM	36,086	2,102,186	0.017166	108,305	1,859	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	332,336	19,815,888	0.016771	1,080,503	18,121	54.00	
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00	
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00	
60.00	06000	LABORATORY	181,912	14,933,927	0.012181	1,614,855	19,671	60.00	
65.00	06500	RESPIRATORY THERAPY	56,579	1,877,292	0.030139	826,831	24,920	65.00	
66.00	06600	PHYSICAL THERAPY	70,448	2,860,524	0.024628	182,472	4,494	66.00	
67.00	06700	OCCUPATIONAL THERAPY	23,812	1,158,597	0.020552	200,749	4,126	67.00	
68.00	06800	SPEECH PATHOLOGY	2,916	563,431	0.005175	33,140	171	68.00	
69.00	06900	ELECTROCARDIOLOGY	39,398	3,530,266	0.011160	595,372	6,644	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,285	3,513,661	0.007196	723,558	5,207	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,210	724,282	0.016858	38,420	648	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	90,253	13,242,482	0.006815	3,076,598	20,967	73.00	
76.00	03020	SLEEP LAB	49,945	918,376	0.054384	6,339	345	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	37,478	531,002	0.070580	1,320	93	90.00	
91.00	09100	EMERGENCY	286,403	14,274,010	0.020065	11,353	228	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,302,481	0.000000	876	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50-199)	1,675,243	93,002,932		9,089,629	129,232	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,654,527	0.000000	0.000000	588,938	50.00
51.00	05100	RECOVERY ROOM	0	2,102,186	0.000000	0.000000	108,305	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,815,888	0.000000	0.000000	1,080,503	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	14,933,927	0.000000	0.000000	1,614,855	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,877,292	0.000000	0.000000	826,831	65.00
66.00	06600	PHYSICAL THERAPY	0	2,860,524	0.000000	0.000000	182,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,158,597	0.000000	0.000000	200,749	67.00
68.00	06800	SPEECH PATHOLOGY	0	563,431	0.000000	0.000000	33,140	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,530,266	0.000000	0.000000	595,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,513,661	0.000000	0.000000	723,558	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	724,282	0.000000	0.000000	38,420	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,242,482	0.000000	0.000000	3,076,598	73.00
76.00	03020	SLEEP LAB	0	918,376	0.000000	0.000000	6,339	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	531,002	0.000000	0.000000	1,320	90.00
91.00	09100	EMERGENCY	0	14,274,010	0.000000	0.000000	11,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,302,481	0.000000	0.000000	876	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0					95.00
200.00		Total (lines 50-199)	0	93,002,932			9,089,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRASOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 SLEEP LAB	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.175286	0	2,249,342	0	0	50.00
51.00	05100 RECOVERY ROOM	0.205367	0	469,893	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140790	0	5,748,662	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.165506	0	4,065,734	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.357681	0	187,478	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.259494	0	944,583	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289045	0	225,689	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.343877	0	285,714	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.105954	0	1,291,172	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143	0	415,906	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.301526	0	346,473	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151874	0	2,598,676	0	0	73.00
76.00	03020 SLEEP LAB	0.342637	0	257,406	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.951908	0	245,469	0	0	90.00
91.00	09100 EMERGENCY	0.410390	0	3,890,187	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732706	0	523,362	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.178253	0	0	0	0	95.00
200.00	Subtotal (see instructions)		0	23,745,746	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	23,745,746	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	394,278	0	50.00
51.00	05100 RECOVERY ROOM	96,501	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	809,354	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	672,903	0	60.00
65.00	06500 RESPIRATORY THERAPY	67,057	0	65.00
66.00	06600 PHYSICAL THERAPY	245,114	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	65,234	0	67.00
68.00	06800 SPEECH PATHOLOGY	98,250	0	68.00
69.00	06900 ELECTROCARDIOLOGY	136,805	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42,898	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	104,471	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	394,671	0	73.00
76.00	03020 SLEEP LAB	88,197	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	233,664	0	90.00
91.00	09100 EMERGENCY	1,596,494	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	383,470	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	5,429,361	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	5,429,361	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318

Period: From 01/01/2012

Worksheet D

Component CCN: 15Z318

To 12/31/2012

Part V  
Date/Time Prepared:  
5/30/2013 4:28 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.175286	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0.205367	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.140790	0	0	0	0 54.00
54.01 05401 ULTRASOUND	0.000000	0	0	0	0 54.01
56.00 05600 RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
60.00 06000 LABORATORY	0.165506	0	0	0	0 60.00
65.00 06500 RESPIRATORY THERAPY	0.357681	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.259494	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.289045	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.343877	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.105954	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.301526	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.151874	0	0	0	0 73.00
76.00 03020 SLEEP LAB	0.342637	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0.951908	0	0	0	0 90.00
91.00 09100 EMERGENCY	0.410390	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732706	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.178253		0		0 95.00
200.00	Subtotal (see instructions)		0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:28 pm
		Component CCN: 15Z318	Title XVIII	Swing Beds - SNF
				Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	SLEEP LAB	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	981,299	0	981,299	4,178	234.87	30.00
31.00	03100	INTENSIVE CARE UNIT	120,112		120,112	607	197.88	31.00
43.00	04300	NURSERY	20,513		20,513	476	43.09	43.00
200.00		Total (lines 30-199)	1,121,924		1,121,924	5,261		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX Hospital		PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	203	47,679			30.00
31.00	03100	INTENSIVE CARE UNIT	19	3,760			31.00
43.00	04300	NURSERY	51	2,198			43.00
200.00		Total (lines 30-199)	273	53,637			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/30/2013 4:28 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	430,182	11,654,527	0.036911	437,407	16,145	50.00
51.00	05100	RECOVERY ROOM	36,086	2,102,186	0.017166	37,789	649	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	332,336	19,815,888	0.016771	136,294	2,286	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	181,912	14,933,927	0.012181	231,650	2,822	60.00
65.00	06500	RESPIRATORY THERAPY	56,579	1,877,292	0.030139	63,243	1,906	65.00
66.00	06600	PHYSICAL THERAPY	70,448	2,860,524	0.024628	6,964	172	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,812	1,158,597	0.020552	3,177	65	67.00
68.00	06800	SPEECH PATHOLOGY	2,916	563,431	0.005175	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,398	3,530,266	0.011160	60,940	680	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,285	3,513,661	0.007196	136,473	982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,210	724,282	0.016858	1,618	27	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,253	13,242,482	0.006815	434,507	2,961	73.00
76.00	03020	SLEEP LAB	49,945	918,376	0.054384	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	37,478	531,002	0.070580	625	44	90.00
91.00	09100	EMERGENCY	286,403	14,274,010	0.020065	45,311	909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	220,780	1,302,481	0.169507	9	2	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,896,023	93,002,932		1,596,007	29,650	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
43.00	04300	NURSERY	0	0	0	0	0 43.00	
200.00		Total (lines 30-199)	0	0	0	0	0 200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,178	0.00	203	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	607	0.00	19	0	31.00	
43.00	04300	NURSERY	476	0.00	51	0	43.00	
200.00		Total (lines 30-199)	5,261		273	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,654,527	0.000000	0.000000	437,407	50.00
51.00	05100	RECOVERY ROOM	0	2,102,186	0.000000	0.000000	37,789	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,815,888	0.000000	0.000000	136,294	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	14,933,927	0.000000	0.000000	231,650	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,877,292	0.000000	0.000000	63,243	65.00
66.00	06600	PHYSICAL THERAPY	0	2,860,524	0.000000	0.000000	6,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,158,597	0.000000	0.000000	3,177	67.00
68.00	06800	SPEECH PATHOLOGY	0	563,431	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,530,266	0.000000	0.000000	60,940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,513,661	0.000000	0.000000	136,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	724,282	0.000000	0.000000	1,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,242,482	0.000000	0.000000	434,507	73.00
76.00	03020	SLEEP LAB	0	918,376	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	531,002	0.000000	0.000000	625	90.00
91.00	09100	EMERGENCY	0	14,274,010	0.000000	0.000000	45,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,302,481	0.000000	0.000000	9	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	93,002,932			1,596,007	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:28 pm
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.175286	0	885,683	0	0	50.00
51.00	05100 RECOVERY ROOM	0.205367	0	64,398	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140790	0	686,618	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.165506	0	650,132	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.357681	0	21,969	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.259494	0	44,667	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289045	0	37,527	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.343877	0	16,160	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.105954	0	110,716	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143	0	52,755	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.301526	0	32,991	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151874	0	498,728	0	0	73.00
76.00	03020 SLEEP LAB	0.342637	0	30,726	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.951908	0	25,192	0	0	90.00
91.00	09100 EMERGENCY	0.410390	0	162,320	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732706	0	75,703	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.178253	0	225,713	0	0	95.00
200.00	Subtotal (see instructions)		0	3,621,998	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	3,621,998	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:28 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	155,248	0	50.00
51.00	05100 RECOVERY ROOM	13,225	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	96,669	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	107,601	0	60.00
65.00	06500 RESPIRATORY THERAPY	7,858	0	65.00
66.00	06600 PHYSICAL THERAPY	11,591	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,847	0	67.00
68.00	06800 SPEECH PATHOLOGY	5,557	0	68.00
69.00	06900 ELECTROCARDIOLOGY	11,731	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,441	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,948	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	75,744	0	73.00
76.00	03020 SLEEP LAB	10,528	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	23,980	0	90.00
91.00	09100 EMERGENCY	66,615	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	55,468	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	40,234	0	95.00
200.00	Subtotal (see instructions)	708,285	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	708,285	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2013 4:28 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,178	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,238	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		580	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,815	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)		528	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		4,830,578	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)		588,845	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,241,733	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,018,123	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,018,123	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.845283	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)		1,549.76	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)		4,241,733	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,015.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,842,679	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)		1,842,679	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	859,098	607	1,415.32	285	403,366		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)					1,582,662		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,828,707		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)					536,052		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)					536,052		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)						940	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,015.25	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						954,335	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2013 4:28 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,178	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,238	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		203	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)		476	15.00
16.00	Nursery days (title V or XIX only)		51	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,830,578	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,830,578	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,018,123	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,018,123	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.962626	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)		1,549.76	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)		4,830,578	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,156.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		234,707	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)		234,707	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XIX		Hospital		PPS			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	128,083	476	269.08	51	13,723		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	859,098	607	1,415.32	19	26,891		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)					273,514		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					548,835		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)					53,637		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					29,650		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					83,287		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					465,548		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)					940		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,156.19		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,086,819		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151318		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	981,299	4,830,578	0.203143	1,086,819	220,780	90.00
91.00	Nursing School cost	0	4,830,578	0.000000	1,086,819	0	91.00
92.00	Allied health cost	0	4,830,578	0.000000	1,086,819	0	92.00
93.00	All other Medical Education	0	4,830,578	0.000000	1,086,819	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		2,173,235		30.00
31.00	03100 INTENSIVE CARE UNIT		521,799		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.175286	588,938	103,233	50.00
51.00	05100 RECOVERY ROOM	0.205367	108,305	22,242	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140790	1,080,503	152,124	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.165506	1,614,855	267,268	60.00
65.00	06500 RESPIRATORY THERAPY	0.357681	826,831	295,742	65.00
66.00	06600 PHYSICAL THERAPY	0.259494	182,472	47,350	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289045	200,749	58,025	67.00
68.00	06800 SPEECH PATHOLOGY	0.343877	33,140	11,396	68.00
69.00	06900 ELECTROCARDIOLOGY	0.105954	595,372	63,082	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143	723,558	74,630	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.301526	38,420	11,585	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151874	3,076,598	467,255	73.00
76.00	03020 SLEEP LAB	0.342637	6,339	2,172	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.951908	1,320	1,257	90.00
91.00	09100 EMERGENCY	0.410390	11,353	4,659	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.732706	876	642	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		9,089,629	1,582,662	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		9,089,629		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15Z318		Date/Time Prepared: 5/30/2013 4:28 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.175286	0	50.00
51.00	05100	RECOVERY ROOM	0.205367	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140790	17,633	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.165506	55,327	60.00
65.00	06500	RESPIRATORY THERAPY	0.357681	138,954	65.00
66.00	06600	PHYSICAL THERAPY	0.259494	284,905	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289045	268,515	67.00
68.00	06800	SPEECH PATHOLOGY	0.343877	20,087	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105954	1,373	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143	68,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.301526	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151874	240,331	73.00
76.00	03020	SLEEP LAB	0.342637	903	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.951908	0	90.00
91.00	09100	EMERGENCY	0.410390	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732706	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,096,947	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,096,947	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 4:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		245,351	30.00
31.00	03100	INTENSIVE CARE UNIT		67,519	31.00
43.00	04300	NURSERY		39,816	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.175286	437,407	50.00
51.00	05100	RECOVERY ROOM	0.205367	37,789	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140790	136,294	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.165506	231,650	60.00
65.00	06500	RESPIRATORY THERAPY	0.357681	63,243	65.00
66.00	06600	PHYSICAL THERAPY	0.259494	6,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289045	3,177	67.00
68.00	06800	SPEECH PATHOLOGY	0.343877	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.105954	60,940	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.103143	136,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.301526	1,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151874	434,507	73.00
76.00	03020	SLEEP LAB	0.342637	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.951908	625	90.00
91.00	09100	EMERGENCY	0.410390	45,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.732706	9	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,596,007	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,596,007	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			5,429,361 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,429,361 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,483,655 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			48,034 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,913,414 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)			1,522,207 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)			1,522,207 30.00
31.00	Primary payer payments			489 31.00
32.00	Subtotal (line 30 minus line 31)			1,521,718 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			352,210 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			352,210 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			334,242 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,873,928 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,873,928 40.00
41.00	Interim payments			2,507,959 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)			-634,031 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151318

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 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		3,015,574		2,507,959	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,015,574		2,507,959	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		331,753		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		634,031	6.02	
7.00	Total Medicare program liability (see instructions)		3,347,327		1,873,928	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: 151318  
Component CCN: 15Z318

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 4:28 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		690,806		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		690,806		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		117,101		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		807,907		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,193 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,100 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			223 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,845 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			102,841,584 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			431,959 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			2,037,109 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,643,307 8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			1,643,307 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151318

Period:

Worksheet E-2

Component CCN: 15Z318

From 01/01/2012  
To 12/31/2012

Date/Time Prepared:  
5/30/2013 4:28 pm

		Title XVIII		Swing Beds - SNF	
		Cost			
		Part A	Part B		
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	541,413	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)	266,494	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	528	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)	807,907	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	807,907	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)	807,907	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)	807,907	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)	807,907	0	19.00	
20.00	Interim payments	690,806	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)	117,101	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151318	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/30/2013 4:28 pm
		Title XVIII	Hospital	Cost
		1.00		
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		3,828,707	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)		3,828,707	4.00
5.00	Primary payer payments		1,920	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,865,074	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,865,074	19.00
20.00	Deductibles (exclude professional component)		514,396	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		3,350,678	22.00
23.00	Coinsurance		2,312	23.00
24.00	Subtotal (line 22 minus line 23)		3,348,366	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		-1,039	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		-1,039	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-2,609	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,347,327	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)		3,347,327	30.00
31.00	Interim payments		3,015,574	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)		331,753	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

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

Provider CCN: 151318

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

Worksheet G

Date/Time Prepared:  
5/30/2013 4:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-414,124	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,381,211	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,783,929	0	0	0	6.00
7.00	Inventory	825,777	0	0	0	7.00
8.00	Prepaid expenses	203,445	0	0	0	8.00
9.00	Other current assets	1,505,321	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,717,701	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	254,435	0	0	0	13.00
14.00	Accumulated depreciation	-45,692	0	0	0	14.00
15.00	Buildings	10,415,130	0	0	0	15.00
16.00	Accumulated depreciation	-1,555,761	0	0	0	16.00
17.00	Leasehold improvements	5,039,194	0	0	0	17.00
18.00	Accumulated depreciation	-513,592	0	0	0	18.00
19.00	Fixed equipment	1,109,000	0	0	0	19.00
20.00	Accumulated depreciation	-183,724	0	0	0	20.00
21.00	Automobiles and trucks	372,241	0	0	0	21.00
22.00	Accumulated depreciation	-260,150	0	0	0	22.00
23.00	Major movable equipment	5,317,312	0	0	0	23.00
24.00	Accumulated depreciation	-2,837,415	0	0	0	24.00
25.00	Minor equipment depreciable	1,203,688	0	0	0	25.00
26.00	Accumulated depreciation	-636,458	0	0	0	26.00
27.00	HIT designated Assets	2,038,462	0	0	0	27.00
28.00	Accumulated depreciation	-178,698	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)	20,037,972	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,451,865	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,451,865	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,207,538	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	746,138	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,182,782	0	0	0	38.00
39.00	Payroll taxes payable	226,531	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	7,612,794	0	0	0	43.00
44.00	Other current liabilities	718,453	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,486,698	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,486,698	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	18,720,840				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)	18,720,840	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,207,538	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151318

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

Worksheet G-1

Date/Time Prepared:  
5/30/2013 4:28 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		6,158,745		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,801,790			2.00
3.00	Total (sum of line 1 and line 2)		11,960,535		0	3.00
4.00	REMOVAL OF CLINIC ENTITY EQUITY	6,760,312		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		6,760,312		0	10.00
11.00	Subtotal (line 3 plus line 10)		18,720,847		0	11.00
12.00	ROUNDING	7		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		7		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,720,840		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151318

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

Worksheet G-1

Date/Time Prepared:  
5/30/2013 4:28 pm

	Endowment Fund	Plant Fund			
		6.00	7.00		
1.00	Fund balances at beginning of period	0			0
2.00	Net income (loss) (from Wkst. G-3, line 29)				
3.00	Total (sum of line 1 and line 2)	0			0
4.00	REMOVAL OF CLINIC ENTITY EQUITY		0		
5.00			0		
6.00			0		
7.00			0		
8.00			0		
9.00			0		
10.00	Total additions (sum of line 4-9)	0			0
11.00	Subtotal (line 3 plus line 10)	0			0
12.00	ROUNDING		0		
13.00			0		
14.00			0		
15.00			0		
16.00			0		
17.00			0		
18.00	Total deductions (sum of lines 12-17)	0			0
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151318

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2013 4:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	5,018,123		5,018,123	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,018,123		5,018,123	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	813,467		813,467	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)	813,467		813,467	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,831,590		5,831,590	17.00
18.00	Ancillary services	20,174,223	56,721,216	76,895,439	18.00
19.00	Outpatient services	626,790	15,480,702	16,107,492	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,007,063	4,007,063	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,632,603	76,208,981	102,841,584	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,816,743		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,816,743		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151318

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

Worksheet G-3

Date/Time Prepared:  
5/30/2013 4:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	102,841,584	1.00
2.00	Less contractual allowances and discounts on patients' accounts	65,750,028	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,091,556	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,816,743	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,274,813	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	68,882	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	10,591	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,255	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,617	21.00
22.00	Rental of hospital space	20,813	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDI CARE HI TECH INCENTIVE	1,400,376	24.00
24.01	FITNESS REVENUE	240	24.01
24.02	SILVER RECOVERY	1,706	24.02
24.03	MISC REVENUE	18,497	24.03
25.00	Total other income (sum of lines 6-24)	1,526,977	25.00
26.00	Total (line 5 plus line 25)	5,801,790	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)	5,801,790	29.00