

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: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/30/2013 4:09 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2013	Time: 4:09 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 HENRY COUNTY MEMORIAL HOSPITAL (150030) 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			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	48,451	-132,964	-169,110	-537,141	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	48,451	-132,964	-169,110	-537,141	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: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 3:52 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1000 NORTH 16TH STREET			PO Box:						1.00	
2.00	City: NEW CASTLE			State: IN		Zip Code: 47392-		County: HENRY		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		HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)						9		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			566	0	0	0	1,215	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 3:52 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.	1				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	01/01/2012	12/31/2012			38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N				39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150030

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

Worksheet S-2
Part I
Date/Time Prepared:
5/30/2013 3:52 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	
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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 3:52 pm		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	320,292	0	0	
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
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.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		
				1.00	
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	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

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								1.00	
Multi campus									
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	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								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: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 3:52 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/01/2013	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: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 3:52 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	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
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
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/01/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 150030

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	80	29,280	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,280	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		90	32,940	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		90				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
	I/P Days / O/P Visi ts / Tri ps			Full Time Equival ents		
Component	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol l	
	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)	4,746	566	8,395			1.00
2.00 HMO	162	1,215				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,746	566	8,395			7.00
8.00 INTENSIVE CARE UNIT	1,078	0	1,618			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	768			13.00
14.00 Total (see instructions)	5,824	566	10,781	0.00	452.96	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	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	3,388	196	5,866	0.00	5.23	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE	4,090	228	8,506	0.00	5.12	24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150030

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents							
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll						
	6.00	7.00	8.00	9.00	10.00						
27.00	Total (sum of lines 14-26)					0.00	463.31	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			
Component	Full Time Equivalents	Discharges									
	Nonpaid Workers	Title V	Title VIII	Title XIX	Total All Patients						
	11.00	12.00	13.00	14.00	15.00						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)							1.00			
2.00	HMO						41	2.00			
3.00	HMO IPF Subprovider							3.00			
4.00	HMO IRF Subprovider							4.00			
5.00	Hospital Adults & Peds. Swing Bed SNF							5.00			
6.00	Hospital Adults & Peds. Swing Bed NF							6.00			
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)							7.00			
8.00	INTENSIVE CARE UNIT							8.00			
9.00	CORONARY CARE UNIT							9.00			
10.00	BURN INTENSIVE CARE UNIT							10.00			
11.00	SURGICAL INTENSIVE CARE UNIT							11.00			
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00			
13.00	NURSERY							13.00			
14.00	Total (see instructions)					0.00	0	1,299	149	2,621	14.00
15.00	CAH visits										15.00
16.00	SUBPROVIDER - IPF										16.00
17.00	SUBPROVIDER - IRF					0.00	0	0	0	0	17.00
18.00	SUBPROVIDER					0.00	0	0	0	0	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					0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)										23.00
24.00	HOSPICE					0.00					24.00
25.00	CMHC - CMHC										25.00
26.00	RURAL HEALTH CLINIC					0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					0.00					26.25
27.00	Total (sum of lines 14-26)					0.00					27.00
28.00	Observation Bed Days										28.00
29.00	Ambulance Trips										29.00
30.00	Employee discount days (see instruction)										30.00
31.00	Employee discount days - IRF										31.00
32.00	Labor & delivery days (see instructions)										32.00
33.00	LTCH non-covered days										33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part II Date/Time Prepared: 5/30/2013 3:52 pm			
	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	24,032,837	0	24,032,837	963,689.00	24.94	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,083,882	195,014	1,278,896	44,484.00	28.75	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		930,510	0	930,510	22,715.00	40.96	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		80,004	0	80,004	678.00	118.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		7,705,395	0	7,705,395			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		239,553	0	239,553			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	183,094	0	183,094	7,714.00	23.74	26.00
27.00	Administrative & General	5.00	4,401,788	0	4,401,788	144,682.00	30.42	27.00
28.00	Administrative & General under contract (see inst.)		642,232	0	642,232	5,010.00	128.19	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	968,635	0	968,635	45,344.00	21.36	30.00
31.00	Laundry & Linen Service	8.00	150,885	-27,180	123,705	10,828.00	11.42	31.00
32.00	Housekeeping	9.00	457,378	-32,073	425,305	40,835.00	10.42	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	688,023	-417,988	270,035	19,360.00	13.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	282,227	282,227	20,252.00	13.94	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,428,884	0	1,428,884	37,789.00	37.81	38.00
39.00	Central Services and Supply	14.00	337,038	0	337,038	15,924.00	21.17	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	891,096	0	891,096	40,729.00	21.88	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150030

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hou rs Rel ated to Sal ari es i n col . 4	Average Hou rly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150030

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2013 3:52 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	24,675,069	0	24,675,069	968,699.00	25.47	1.00
2.00	Excluded area salaries (see instructions)	1,083,882	195,014	1,278,896	44,484.00	28.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,591,187	-195,014	23,396,173	924,215.00	25.31	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,010,514	0	1,010,514	23,393.00	43.20	4.00
5.00	Subtotal wage-related costs (see inst.)	7,705,395	0	7,705,395	0.00	32.93	5.00
6.00	Total (sum of lines 3 thru 5)	32,307,096	-195,014	32,112,082	947,608.00	33.89	6.00
7.00	Total overhead cost (see instructions)	10,149,053	-195,014	9,954,039	388,467.00	25.62	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2013 3:52 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,002,990	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		3,856	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		4,167,889	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		117,267	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		257,883	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		291,472	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		194,557	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,650,722	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		18,760	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,705,396	24.00
Part B - Other than Core Related Cost				
25.00	EXCLUDED BENEFITS		239,553	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/30/2013 3:52 pm
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150030 Component CCN: 157430		Period: From 01/01/2012 To 12/31/2012		Worksheet S-4 Date/Time Prepared: 5/30/2013 3:52 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	219.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,251	0	95	22	1,368	
22.00	Skilled Nursing Visit Charges	288,330	0	21,839	5,060	315,229	
23.00	Physical Therapy Visits	1,328	0	39	27	1,394	
24.00	Physical Therapy Visit Charges	304,967	0	8,970	6,210	320,147	
25.00	Occupational Therapy Visits	241	0	0	6	247	
26.00	Occupational Therapy Visit Charges	52,770	0	0	1,540	54,310	
27.00	Speech Pathology Visits	0	0	0	0	0	
28.00	Speech Pathology Visit Charges	0	0	0	0	0	
29.00	Medical Social Service Visits	0	0	0	0	0	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	
31.00	Home Health Aide Visits	373	0	0	6	379	
32.00	Home Health Aide Visit Charges	40,214	0	0	648	40,862	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,193	0	134	61	3,388	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	686,281	0	30,809	13,458	730,548	
36.00	Total Number of Episodes (standard/non outlier)	211		42	5	258	
37.00	Total Number of Outlier Episodes		0		0	0	
38.00	Total Non-Routine Medical Supply Charges	4,519	0	187	68	4,774	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150030
Component CCN: 151564

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
5/30/2013 3:52 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	3,925	207	355	0	645	4,777	
3.00	Inpatient Respite Care	14	0	0	0	0	14	
4.00	General Inpatient Care	82	21	0	0	0	103	
5.00	Total Hospice Days	4,021	228	355	0	645	4,894	
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	70	8	43	0	14	92	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	57.44	28.50	8.26	0.00	46.07	53.20	
9.00	Unduplicated Census Count	62	8	38	0	12	82	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/30/2013 3:52 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.320592	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,644,231	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		563,273	5.00	
6.00	Medicaid charges		21,948,681	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,036,572	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)		2,829,068	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,829,068	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,459,318	0	3,459,318	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,109,030	0	1,109,030	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,109,030	0	1,109,030	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		8,958,349	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		23,138	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		8,935,211	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,864,557	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		3,973,587	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,802,655	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150030

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

Worksheet A
Date/Time Prepared:
5/30/2013 3:52 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	
GENERAL SERVICE COST CENTERS							
1.00	00100		4,955,852	4,955,852	-47,953	4,907,899	1.00
2.00	00200		0	0	637,646	637,646	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	183,094	6,549,381	6,732,475	0	6,732,475	4.00
5.00	00500	4,401,788	9,084,103	13,485,891	0	13,485,891	5.00
7.00	00700	968,635	1,635,604	2,604,239	0	2,604,239	7.00
8.00	00800	150,885	109,140	260,025	-46,840	213,185	8.00
9.00	00900	457,378	252,338	709,716	-49,768	659,948	9.00
10.00	01000	688,023	540,115	1,228,138	-746,119	482,019	10.00
11.00	01100	0	0	0	503,782	503,782	11.00
13.00	01300	1,428,884	286,444	1,715,328	0	1,715,328	13.00
14.00	01400	337,038	311,029	648,067	-50	648,017	14.00
15.00	01500	0	3,250,763	3,250,763	-144,049	3,106,714	15.00
16.00	01600	891,096	204,786	1,095,882	0	1,095,882	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,520,227	446,604	3,966,831	-653,015	3,313,816	30.00
31.00	03100	1,047,827	126,843	1,174,670	0	1,174,670	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	569,728	569,728	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,947,210	981,957	2,929,167	-177,966	2,751,201	50.00
52.00	05200	0	0	0	81,390	81,390	52.00
54.00	05400	1,384,220	907,742	2,291,962	-283,654	2,008,308	54.00
57.00	05700	179,078	672,222	851,300	0	851,300	57.00
58.00	05800	107,800	482,970	590,770	0	590,770	58.00
59.00	05900	16,871	542,815	559,686	0	559,686	59.00
60.00	06000	1,511,102	1,613,636	3,124,738	0	3,124,738	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	428,568	102,401	530,969	-835	530,134	65.00
66.00	06600	1,033,754	887,561	1,921,315	-515	1,920,800	66.00
68.00	06800	45,638	16,297	61,935	0	61,935	68.00
69.00	06900	82,804	73,612	156,416	0	156,416	69.00
71.00	07100	0	3,534,157	3,534,157	-3,097,051	437,106	71.00
72.00	07200	0	0	0	3,097,051	3,097,051	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03021	102,082	9,051	111,133	0	111,133	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	2,034,953	832,620	2,867,573	0	2,867,573	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	488,220	132,860	621,080	0	621,080	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
116.00	11600	295,644	309,877	605,521	-28,516	577,005	116.00
118.00		23,732,819	38,852,780	62,585,599	-386,734	62,198,865	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	300,018	208,003	508,021	-164	507,857	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	47,953	47,953	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	387,065	387,065	0	387,065	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	338,945	338,945	194.09
200.00		24,032,837	39,447,848	63,480,685	0	63,480,685	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150030

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

Worksheet A
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-65,286	4,842,613	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	637,646	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	731,600	7,464,075	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,649,826	8,836,065	5.00
7.00	00700	OPERATION OF PLANT	0	2,604,239	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,185	8.00
9.00	00900	HOUSEKEEPING	0	659,948	9.00
10.00	01000	DIETARY	-81,024	400,995	10.00
11.00	01100	CAFETERIA	-365,111	138,671	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,715,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	648,017	14.00
15.00	01500	PHARMACY	-395,359	2,711,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,428	1,074,454	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,368	3,312,448	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,174,670	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	569,728	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,751,201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	81,390	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,979	1,979,329	54.00
57.00	05700	CT SCAN	-467,512	383,788	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-303,811	286,959	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	559,686	59.00
60.00	06000	LABORATORY	-8,455	3,116,283	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-12,392	517,742	65.00
66.00	06600	PHYSICAL THERAPY	-692,430	1,228,370	66.00
68.00	06800	SPEECH PATHOLOGY	0	61,935	68.00
69.00	06900	ELECTROCARDIOLOGY	0	156,416	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	437,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,097,051	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03021	CARDIAC REHABILITATION	0	111,133	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	0	2,867,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-7,408	613,672	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	577,005	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,368,789	55,830,076	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	507,857	192.00
194.00	07950	MCH	0	0	194.00
194.01	07951	RENTAL	0	47,953	194.01
194.02	07952	CMHS	0	0	194.02
194.03	07953	MCH	0	0	194.03
194.04	07954	WIC	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	387,065	194.05
194.06	07956	LIFELINE	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	194.07
194.08	07958	OB DRS	0	0	194.08
194.09	07959	THE WATERS	0	338,945	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-6,368,789	57,111,896	200.00

RECLASSIFICATIONS

Provider CCN: 150030

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

Worksheet A-6

Date/Time Prepared:
5/30/2013 3:52 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - OB/NURSERY/L&D					
1.00	NURSERY	43.00	505,467	64,261	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	72,210	9,180	2.00
	TOTALS		577,677	73,441	
B - CAFETERIA					
1.00	CAFETERIA	11.00	282,227	221,555	1.00
	TOTALS		282,227	221,555	
C - WATERS EXCLUSIONS					
1.00	THE WATERS	194.09	195,014	143,931	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		195,014	143,931	
D - DEPRECIATION POB					
1.00	RENTAL	194.01	0	47,953	1.00
	TOTALS		0	47,953	
E - EQUIPMENT RENTAL					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	637,646	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
	TOTALS		0	637,646	
F - IMPLANTABLE DEVICE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,097,051	1.00
	TOTALS		0	3,097,051	
500.00	Grand Total: Increases		1,054,918	4,221,577	500.00

RECLASSIFICATIONS

Provider CCN: 150030

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

Worksheet A-6

Date/Time Prepared:
5/30/2013 3:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - OB/NURSERY/L&D							
1.00	ADULTS & PEDIATRICS	30.00	577,677	73,441	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		577,677	73,441			
B - CAFETERIA							
1.00	DIETARY	10.00	282,227	221,555	0		1.00
	TOTALS		282,227	221,555			
C - WATERS EXCLUSIONS							
1.00	LAUNDRY & LINEN SERVICE	8.00	27,180	19,660	0		1.00
2.00	HOUSEKEEPING	9.00	32,073	17,695	0		2.00
3.00	DIETARY	10.00	135,761	106,576	0		3.00
	TOTALS		195,014	143,931			
D - DEPRECIATION POB							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	47,953	9		1.00
	TOTALS		0	47,953			
E - EQUIPMENT RENTAL							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	50	9		1.00
2.00	PHARMACY	15.00	0	144,049	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,897	0		3.00
4.00	OPERATING ROOM	50.00	0	177,966	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	283,654	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	835	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	515	0		7.00
8.00	HOSPICE	116.00	0	28,516	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	164	0		9.00
	TOTALS		0	637,646			
F - IMPLANTABLE DEVICE							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,097,051	0		1.00
	TOTALS		0	3,097,051			
500.00	Grand Total: Decreases		1,054,918	4,221,577			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0	0	0	1.00
2.00	Land Improvements	1,643,952	0	0	22,355	2.00
3.00	Buildings and Fixtures	38,463,416	2,762,423	0	5,050,953	3.00
4.00	Building Improvements	237,996	0	0	32,701	4.00
5.00	Fixed Equipment	15,332,551	7,124	0	629,210	5.00
6.00	Movable Equipment	25,085,454	4,910,022	0	384,121	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	80,809,369	7,679,569	0	6,119,340	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	80,809,369	7,679,569	0	6,119,340	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	46,000	0			1.00
2.00	Land Improvements	1,621,597	0			2.00
3.00	Buildings and Fixtures	36,174,886	0			3.00
4.00	Building Improvements	205,295	0			4.00
5.00	Fixed Equipment	14,710,465	0			5.00
6.00	Movable Equipment	29,611,355	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	82,369,598	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	82,369,598	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,436,631	0	519,221	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,436,631	0	519,221	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,955,852				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,955,852				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	37,842,483	0	37,842,483	0.459423	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	44,527,115	0	44,527,115	0.540577	0	2.00
3.00	Total (sum of lines 1-2)	82,369,598	0	82,369,598	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,388,678	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	637,646	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,026,324	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	453,935	0	0	0	4,842,613	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	637,646	2.00
3.00	Total (sum of lines 1-2)	453,935	0	0	0	5,480,259	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150030

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

Worksheet A-8

Date/Time Prepared:
5/30/2013 3:52 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00		4.00
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-65,286	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00		0 2.00
3.00	Investment income - other (chapter 2)		0			0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-11,346	ADMINISTRATIVE & GENERAL		5.00		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00		0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-16,088	ADMINISTRATIVE & GENERAL		5.00		0 7.00
8.00	Television and radio service (chapter 21)		0			0.00		0 8.00
9.00	Parking lot (chapter 21)		0			0.00		0 9.00
10.00	Provider-based physician adjustment	A-8-2	-8,455					0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00		0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,527,583					0 12.00
13.00	Laundry and linen service		0			0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-365,111	CAFETERIA		11.00		0 14.00
15.00	Rental of quarters to employee and others		0			0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00		0 16.00
17.00	Sale of drugs to other than patients		0			0.00		0 17.00
18.00	Sale of medical records and abstracts	B	-21,428	MEDICAL RECORDS & LIBRARY		16.00		0 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00		0 19.00
20.00	Vending machines		0			0.00		0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF		114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT		1.00		0 26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00		0 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***		67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00		0 32.00
33.00	OTHER OP REV - HUMAN RESOURCEC - MIS	B	-361	EMPLOYEE BENEFITS		4.00		0 33.00

Provider CCN: 150030

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

Worksheet A-8

Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 OTHER OP REV	B	-6,998	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00 OTHER OP REV - COPIES RECEIPTS	B	-6	ADMINISTRATIVE & GENERAL	5.00	0 35.00
36.00 OTHER OP REV - PHY REAPP FEES	B	-5,600	ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 OTHER OP REV - DIETARY - MISC DIETARY	B	-5,976	DIETARY	10.00	0 37.00
38.00 OTHER OP REV - DIETARY - OUTSIDE SAL	B	-75,048	DIETARY	10.00	0 38.00
39.00 OTHER OP REV - PHARMACY	B	-395,359	PHARMACY	15.00	0 39.00
40.00 OTHER OP REV - WOMEN & CH UNIT - HLT	B	-70	ADULTS & PEDIATRICS	30.00	0 40.00
41.00 OTHER OP REV - PCU - HLTH PROG REC	B	-1,298	ADULTS & PEDIATRICS	30.00	0 41.00
42.00 OTHER OP REV - ATH TRAINING - HLTH P	B	-20,906	PHYSICAL THERAPY	66.00	0 42.00
43.00 OTHER OP REV - ATH TRAINING - OUTSID	B	-39,815	PHYSICAL THERAPY	66.00	0 43.00
44.00 OTHER OP REV - AQUATICS - HLTH PROG	B	-13,658	PHYSICAL THERAPY	66.00	0 44.00
45.00 OTHER OP REV - PHYSICAL THER - HLTH	B	-725	PHYSICAL THERAPY	66.00	0 45.00
45.01 OTHER OP REV - PHYSICAL THER - EE	B	-17,799	PHYSICAL THERAPY	66.00	0 45.01
45.02 OTHER OP REV - PHYSICAL THER - FIT F	B	-43,003	PHYSICAL THERAPY	66.00	0 45.02
45.03 PUBLIC RELATIONS	A	-80,045	ADMINISTRATIVE & GENERAL	5.00	0 45.03
45.04 AHA & IHA DUES	A	-6,483	ADMINISTRATIVE & GENERAL	5.00	0 45.04
45.05 BENEFIT EXPENSE	A	731,961	EMPLOYEE BENEFITS	4.00	0 45.05
45.06 HAF EXPENSE	A	-4,372,303	ADMINISTRATIVE & GENERAL	5.00	0 45.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,368,789			50.00

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

Provider CCN: 150030

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2013 3:52 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	0	150,957 1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	XRAY	3,295	32,274 2.00
3.00	57.00	CT SCAN	CT SCAN	135,563	603,075 3.00
4.00	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	25,517	37,909 4.00
4.01	66.00	PHYSICAL THERAPY	PHYSICAL THERAPY	189,867	746,391 4.01
4.02	58.00	MAGNETIC RESONANCE IMAGING (MRI)	MRI	146,189	450,000 4.02
4.03	101.00	HOME HEALTH AGENCY	HOME HEALTH AGENCY	18,622	26,030 4.03
5.00	0		0	519,053	2,046,636 5.00

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

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

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

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

6.00	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDATION	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC				100.00

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

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

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

Provider CCN: 150030

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2013 3:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-150,957	0		1.00
2.00	-28,979	0		2.00
3.00	-467,512	0		3.00
4.00	-12,392	0		4.00
4.01	-556,524	0		4.01
4.02	-303,811	0		4.02
4.03	-7,408	0		4.03
5.00	-1,527,583			5.00

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

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

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

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

6.00	MISC		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150030

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2013 3:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	80,004	0	80,004	219,500	678	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			80,004	0	80,004		678	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	71,549	3,577	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			71,549	3,577	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	71,549	8,455	8,455		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	71,549	8,455	8,455		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	4,842,613	4,842,613			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	637,646		637,646		2.00
4.00 00400	EMPLOYEE BENEFITS	7,464,075	25,420	3,131	7,492,626	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,836,065	543,242	66,912	1,382,856	10,829,075 5.00
7.00 00700	OPERATION OF PLANT	2,604,239	1,285,941	158,391	304,306	4,352,877 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	213,185	63,897	7,870	38,863	323,815 8.00
9.00 00900	HOUSEKEEPING	659,948	40,419	4,978	133,614	838,959 9.00
10.00 01000	DIETARY	400,995	134,816	16,605	84,834	637,250 10.00
11.00 01100	CAFETERIA	138,671	36,832	4,537	88,664	268,704 11.00
13.00 01300	NURSING ADMINISTRATION	1,715,328	60,124	7,406	448,898	2,231,756 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	648,017	133,602	16,456	105,884	903,959 14.00
15.00 01500	PHARMACY	2,711,355	29,175	3,593	0	2,744,123 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,074,454	99,011	12,195	279,947	1,465,607 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,312,448	549,816	67,722	924,432	4,854,418 30.00
31.00 03100	INTENSIVE CARE UNIT	1,174,670	216,680	26,689	329,185	1,747,224 31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	569,728	57,303	7,058	158,798	792,887 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,751,201	303,961	37,439	611,735	3,704,336 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	81,390	29,119	3,587	22,685	136,781 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,979,329	218,903	26,963	434,867	2,660,062 54.00
57.00 05700	CT SCAN	383,788	8,181	1,008	56,259	449,236 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	286,959	9,993	1,231	33,866	332,049 58.00
59.00 05900	CARDIAC CATHETERIZATION	559,686	62,272	7,670	5,300	634,928 59.00
60.00 06000	LABORATORY	3,116,283	149,945	18,469	474,728	3,759,425 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	517,742	43,986	5,418	134,639	701,785 65.00
66.00 06600	PHYSICAL THERAPY	1,228,370	20,639	2,542	324,764	1,576,315 66.00
68.00 06800	SPEECH PATHOLOGY	61,935	3,605	444	14,338	80,322 68.00
69.00 06900	ELECTROCARDIOLOGY	156,416	0	0	26,014	182,430 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	437,106	0	0	0	437,106 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	3,097,051	0	0	0	3,097,051 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03021	CARDIAC REHABILITATION	111,133	13,280	1,636	32,070	158,119 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00 09100	EMERGENCY	2,867,573	194,304	23,933	639,301	3,725,111 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	613,672	0	0	153,379	767,051 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0 114.00
116.00 11600	HOSPICE	577,005	0	0	92,880	669,885 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,830,076	4,334,466	533,883	7,337,106	55,062,646 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,846	0	0	18,846 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	507,857	31,080	3,828	94,254	637,019 192.00
194.00 07950	MCH	0	0	0	0	0 194.00
194.01 07951	RENTAL	47,953	0	43,495	0	91,448 194.01
194.02 07952	CMHS	0	0	0	0	0 194.02
194.03 07953	MCH	0	0	0	0	0 194.03
194.04 07954	WIC	0	0	0	0	0 194.04
194.05 07955	OTHER NONREIMBURSABLE COSTS	387,065	0	0	0	387,065 194.05
194.06 07956	LIFELINE	0	0	0	0	0 194.06
194.07 07957	PHILLIPS HALL	0	0	0	0	0 194.07
194.08 07958	OB DRG	0	0	0	0	0 194.08
194.09 07959	THE WATERS	338,945	458,221	56,440	61,266	914,872 194.09
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	57,111,896	4,842,613	637,646	7,492,626	57,111,896 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part I Date/Time Prepared: 5/30/2013 3:52 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	10,829,075			5.00		
7.00	00700	OPERATION OF PLANT	1,018,469	5,371,346		7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	75,765	138,089	537,669	8.00		
9.00	00900	HOUSEKEEPING	196,296	87,350	22,761	1,145,366	9.00	
10.00	01000	DIETARY	149,101	291,355	6,113	23,528	1,107,347	10.00
11.00	01100	CAFETERIA	62,870	79,600	0	10,267	0	11.00
13.00	01300	NURSING ADMINISTRATION	522,177	129,935	0	11,978	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	211,505	288,732	0	14,544	0	14.00
15.00	01500	PHARMACY	642,059	63,050	0	6,844	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	342,917	213,975	0	8,769	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,135,823	1,188,232	108,560	360,184	862,275	30.00
31.00	03100	INTENSIVE CARE UNIT	408,808	468,276	24,411	44,489	166,189	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	185,517	123,840	9,137	4,706	78,883	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	866,726	656,902	96,440	101,169	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,003	62,929	1,305	14,972	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,391	473,079	39,033	52,830	0	54.00
57.00	05700	CT SCAN	105,110	17,680	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	77,691	21,595	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	148,558	134,577	1,273	214	0	59.00
60.00	06000	LABORATORY	879,615	324,051	678	22,458	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	164,201	95,060	0	19,678	0	65.00
66.00	06600	PHYSICAL THERAPY	368,820	44,603	11,813	133,893	0	66.00
68.00	06800	SPEECH PATHOLOGY	18,793	7,790	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,684	0	0	2,139	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,272	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	724,636	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03021	CARDIAC REHABILITATION	36,996	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	871,587	419,918	96,088	74,647	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	179,472	0	0	12,192	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	156,737	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,349,599	5,330,618	417,612	919,501	1,107,347	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,410	40,728	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	149,047	0	266	2,139	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	21,397	0	0	194,423	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	14,693	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	90,564	0	0	0	0	194.05
194.06	07956	LIFELINE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	4,356	29,303	0	194.07
194.08	07958	OB DRS	0	0	7,198	0	0	194.08
194.09	07959	THE WATERS	214,058	0	93,544	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,829,075	5,371,346	537,669	1,145,366	1,107,347	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part I Date/Time Prepared: 5/30/2013 3:52 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	421,441					11.00
13.00	01300	NURSING ADMINISTRATION	25,275	2,921,121				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,655	0	1,429,395			14.00
15.00	01500	PHARMACY	0	0	3,168	3,459,244		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,236	0	429	0	2,058,933	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	81,820	1,001,517	43,234	0	340,965	30.00
31.00	03100	INTENSIVE CARE UNIT	24,663	301,885	12,658	0	139,942	31.00
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	11,212	137,236	0	0	34,019	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,765	670,346	114,210	0	475,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,600	19,581	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,292	0	58,874	0	191,744	54.00
57.00	05700	CT SCAN	3,923	0	13,208	0	48,709	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,685	0	4,516	0	36,339	58.00
59.00	05900	CARDIAC CATHETERIZATION	320	0	11,122	0	3,866	59.00
60.00	06000	LABORATORY	45,014	0	180,276	0	248,958	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	10,989	134,512	1,853	0	24,741	65.00
66.00	06600	PHYSICAL THERAPY	10,349	0	9,144	0	20,102	66.00
68.00	06800	SPEECH PATHOLOGY	17,819	0	118	0	773	68.00
69.00	06900	ELECTROCARDIOLOGY	3,227	0	1,820	0	24,741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	110,294	0	82,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	781,473	0	67,265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,459,244	0	73.00
76.00	03021	CARDIAC REHABILITATION	2,991	36,608	349	0	2,319	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	50,606	619,436	79,180	0	294,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	2,045	0	8,505	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	1,424	0	13,144	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	421,441	2,921,121	1,429,395	3,459,244	2,058,933	118.00
NONREIMBURSABLE COST CENTERS								
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	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	LIFELINE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	421,441	2,921,121	1,429,395	3,459,244	2,058,933	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	9,977,028	0	9,977,028	30.00
31.00	03100	3,338,545	0	3,338,545	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	1,377,437	0	1,377,437	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	6,740,392	0	6,740,392	50.00
52.00	05200	269,171	0	269,171	52.00
54.00	05400	4,134,305	0	4,134,305	54.00
57.00	05700	637,866	0	637,866	57.00
58.00	05800	474,875	0	474,875	58.00
59.00	05900	934,858	0	934,858	59.00
60.00	06000	5,460,475	0	5,460,475	60.00
60.01	06001	0	0	0	60.01
65.00	06500	1,152,819	0	1,152,819	65.00
66.00	06600	2,175,039	0	2,175,039	66.00
68.00	06800	125,615	0	125,615	68.00
69.00	06900	257,041	0	257,041	69.00
71.00	07100	732,400	0	732,400	71.00
72.00	07200	4,670,425	0	4,670,425	72.00
73.00	07300	3,459,244	0	3,459,244	73.00
76.00	03021	237,382	0	237,382	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	6,231,148	0	6,231,148	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	969,265	0	969,265	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	0	0	0	113.00
114.00	11400	0	0	0	114.00
116.00	11600	841,190	0	841,190	116.00
118.00		54,196,520	0	54,196,520	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	63,984	0	63,984	190.00
192.00	19200	788,471	0	788,471	192.00
194.00	07950	0	0	0	194.00
194.01	07951	307,268	0	307,268	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	14,693	0	14,693	194.04
194.05	07955	477,629	0	477,629	194.05
194.06	07956	0	0	0	194.06
194.07	07957	33,659	0	33,659	194.07
194.08	07958	7,198	0	7,198	194.08
194.09	07959	1,222,474	0	1,222,474	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		57,111,896	0	57,111,896	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150030

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	25,420	3,131	28,551	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	543,242	66,912	610,154	5.00
7.00 00700	OPERATION OF PLANT	0	1,285,941	158,391	1,444,332	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	63,897	7,870	71,767	8.00
9.00 00900	HOUSEKEEPING	0	40,419	4,978	45,397	9.00
10.00 01000	DIETARY	0	134,816	16,605	151,421	10.00
11.00 01100	CAFETERIA	0	36,832	4,537	41,369	11.00
13.00 01300	NURSING ADMINISTRATION	0	60,124	7,406	67,530	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	133,602	16,456	150,058	14.00
15.00 01500	PHARMACY	0	29,175	3,593	32,768	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	99,011	12,195	111,206	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	549,816	67,722	617,538	30.00
31.00 03100	INTENSIVE CARE UNIT	0	216,680	26,689	243,369	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	57,303	7,058	64,361	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	303,961	37,439	341,400	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	29,119	3,587	32,706	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	218,903	26,963	245,866	54.00
57.00 05700	CT SCAN	0	8,181	1,008	9,189	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,993	1,231	11,224	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	62,272	7,670	69,942	59.00
60.00 06000	LABORATORY	0	149,945	18,469	168,414	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	43,986	5,418	49,404	65.00
66.00 06600	PHYSICAL THERAPY	0	20,639	2,542	23,181	66.00
68.00 06800	SPEECH PATHOLOGY	0	3,605	444	4,049	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03021	CARDIAC REHABILITATION	0	13,280	1,636	14,916	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	194,304	23,933	218,237	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,334,466	533,883	4,868,349	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,846	0	18,846	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	31,080	3,828	34,908	192.00
194.00 07950	MCH	0	0	0	0	194.00
194.01 07951	RENTAL	0	0	43,495	43,495	194.01
194.02 07952	CMHS	0	0	0	0	194.02
194.03 07953	MCH	0	0	0	0	194.03
194.04 07954	WIC	0	0	0	0	194.04
194.05 07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	194.05
194.06 07956	LIFELINE	0	0	0	0	194.06
194.07 07957	PHILLIPS HALL	0	0	0	0	194.07
194.08 07958	OB DRS	0	0	0	0	194.08
194.09 07959	THE WATERS	0	458,221	56,440	514,661	194.09
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	4,842,613	637,646	5,480,259	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/30/2013 3:52 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	615,429			5.00		
7.00	00700	OPERATION OF PLANT	57,880	1,503,371		7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	4,306	38,649	114,870	8.00		
9.00	00900	HOUSEKEEPING	11,156	24,448	4,863	86,373	9.00	
10.00	01000	DIETARY	8,474	81,547	1,306	1,774	244,845	10.00
11.00	01100	CAFETERIA	3,573	22,279	0	774	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,676	36,367	0	903	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,020	80,812	0	1,097	0	14.00
15.00	01500	PHARMACY	36,489	17,647	0	516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,488	59,889	0	661	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	64,554	332,573	23,192	27,163	190,657	30.00
31.00	03100	INTENSIVE CARE UNIT	23,233	131,064	5,215	3,355	36,746	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,543	34,661	1,952	355	17,442	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,257	183,858	20,604	7,629	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,819	17,613	279	1,129	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,371	132,409	8,339	3,984	0	54.00
57.00	05700	CT SCAN	5,973	4,948	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,415	6,044	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,443	37,666	272	16	0	59.00
60.00	06000	LABORATORY	49,989	90,698	145	1,694	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	9,332	26,606	0	1,484	0	65.00
66.00	06600	PHYSICAL THERAPY	20,960	12,484	2,524	10,097	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,068	2,180	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,426	0	0	161	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,812	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	41,181	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03021	CARDIAC REHABILITATION	2,103	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	49,533	117,530	20,529	5,629	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	10,199	0	0	919	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	8,907	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	588,180	1,491,972	89,220	69,340	244,845	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	251	11,399	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,470	0	57	161	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	1,216	0	0	14,662	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	3,139	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	5,147	0	0	0	0	194.05
194.06	07956	LIFELINE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	931	2,210	0	194.07
194.08	07958	OB DRS	0	0	1,538	0	0	194.08
194.09	07959	THE WATERS	12,165	0	19,985	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	615,429	1,503,371	114,870	86,373	244,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/30/2013 3:52 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	68,333					11.00
13.00	01300	NURSING ADMINISTRATION	4,098	140,284				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,728	0	246,118			14.00
15.00	01500	PHARMACY	0	0	545	87,965		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,416	0	74	0	196,801	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,267	48,096	7,444	0	32,591	30.00
31.00	03100	INTENSIVE CARE UNIT	3,999	14,498	2,180	0	13,376	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,818	6,591	0	0	3,252	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,880	32,193	19,665	0	45,449	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	259	940	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,884	0	10,137	0	18,328	54.00
57.00	05700	CT SCAN	636	0	2,274	0	4,656	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	435	0	778	0	3,473	58.00
59.00	05900	CARDIAC CATHETERIZATION	52	0	1,915	0	370	59.00
60.00	06000	LABORATORY	7,299	0	31,041	0	23,796	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,782	6,460	319	0	2,365	65.00
66.00	06600	PHYSICAL THERAPY	1,678	0	1,575	0	1,921	66.00
68.00	06800	SPEECH PATHOLOGY	2,889	0	20	0	74	68.00
69.00	06900	ELECTROCARDIOLOGY	523	0	313	0	2,365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	18,991	0	7,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	134,556	0	6,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	87,965	0	73.00
76.00	03021	CARDIAC REHABILITATION	485	1,758	60	0	222	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	8,205	29,748	13,634	0	28,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	352	0	813	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	245	0	1,256	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,333	140,284	246,118	87,965	196,801	118.00
NONREIMBURSABLE COST CENTERS								
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	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	LIFELINE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	68,333	140,284	246,118	87,965	196,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150030

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	1,360,597	0	1,360,597	30.00
31.00	03100	478,289	0	478,289	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	141,580	0	141,580	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	711,266	0	711,266	50.00
52.00	05200	54,831	0	54,831	52.00
54.00	05400	461,975	0	461,975	54.00
57.00	05700	27,890	0	27,890	57.00
58.00	05800	26,498	0	26,498	58.00
59.00	05900	118,696	0	118,696	59.00
60.00	06000	374,885	0	374,885	60.00
60.01	06001	0	0	0	60.01
65.00	06500	98,265	0	98,265	65.00
66.00	06600	75,657	0	75,657	66.00
68.00	06800	10,335	0	10,335	68.00
69.00	06900	5,887	0	5,887	69.00
71.00	07100	32,711	0	32,711	71.00
72.00	07200	182,166	0	182,166	72.00
73.00	07300	87,965	0	87,965	73.00
76.00	03021	19,666	0	19,666	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	493,638	0	493,638	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	12,867	0	12,867	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
114.00	11400				114.00
116.00	11600	10,762	0	10,762	116.00
118.00		4,786,426	0	4,786,426	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	30,496	0	30,496	190.00
192.00	19200	43,955	0	43,955	192.00
194.00	07950	0	0	0	194.00
194.01	07951	59,373	0	59,373	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	3,139	0	3,139	194.04
194.05	07955	5,147	0	5,147	194.05
194.06	07956	0	0	0	194.06
194.07	07957	3,141	0	3,141	194.07
194.08	07958	1,538	0	1,538	194.08
194.09	07959	547,044	0	547,044	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		5,480,259	0	5,480,259	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	259,272					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		277,169				2.00
4.00 00400	EMPLOYEE BENEFITS	1,361	1,361	23,849,743			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	29,085	29,085	4,401,788	-10,829,075	46,282,821	5.00
7.00 00700	OPERATION OF PLANT	68,849	68,849	968,635	0	4,352,877	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	3,421	3,421	123,705	0	323,815	8.00
9.00 00900	HOUSEKEEPING	2,164	2,164	425,305	0	838,959	9.00
10.00 01000	DIETARY	7,218	7,218	270,035	0	637,250	10.00
11.00 01100	CAFETERIA	1,972	1,972	282,227	0	268,704	11.00
13.00 01300	NURSING ADMINISTRATION	3,219	3,219	1,428,884	0	2,231,756	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	337,038	0	903,959	14.00
15.00 01500	PHARMACY	1,562	1,562	0	0	2,744,123	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,301	5,301	891,096	0	1,465,607	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	29,437	29,437	2,942,550	0	4,854,418	30.00
31.00 03100	INTENSIVE CARE UNIT	11,601	11,601	1,047,827	0	1,747,224	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	3,068	3,068	505,467	0	792,887	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	16,274	16,274	1,947,210	0	3,704,336	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	72,210	0	136,781	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,720	11,720	1,384,220	0	2,660,062	54.00
57.00 05700	CT SCAN	438	438	179,078	0	449,236	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	107,800	0	332,049	58.00
59.00 05900	CARDIAC CATHETERIZATION	3,334	3,334	16,871	0	634,928	59.00
60.00 06000	LABORATORY	8,028	8,028	1,511,102	0	3,759,425	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	2,355	2,355	428,568	0	701,785	65.00
66.00 06600	PHYSICAL THERAPY	1,105	1,105	1,033,754	0	1,576,315	66.00
68.00 06800	SPEECH PATHOLOGY	193	193	45,638	0	80,322	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	82,804	0	182,430	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	437,106	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,097,051	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03021	CARDIAC REHABILITATION	711	711	102,082	0	158,119	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	10,403	10,403	2,034,953	0	3,725,111	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	488,220	0	767,051	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW-SNF						114.00
116.00 11600	HOSPICE	0	0	295,644	0	669,885	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	232,066	232,066	23,354,711	-10,829,075	44,233,571	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	18,846	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,664	1,664	300,018	0	637,019	192.00
194.00 07950	MCH	0	0	0	0	0	194.00
194.01 07951	RENTAL	0	18,906	0	0	91,448	194.01
194.02 07952	CMHS	0	0	0	0	0	194.02
194.03 07953	MCH	0	0	0	0	0	194.03
194.04 07954	WIC	0	0	0	0	0	194.04
194.05 07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	387,065	194.05
194.06 07956	LIFELINE	0	0	0	0	0	194.06
194.07 07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08 07958	OB DRS	0	0	0	0	0	194.08
194.09 07959	THE WATERS	24,533	24,533	195,014	0	914,872	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,842,613	637,646	7,492,626		10,829,075	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.677732	2.300568	0.314160		0.233976	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			28,551		615,429	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1

Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
205.00 Unit cost multiplier (Wkst. B, Part 11)				0.001197	5A	0.013297	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	133,069				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	707,034			8.00
9.00	00900	HOUSEKEEPING	2,164	29,931	5,355		9.00
10.00	01000	DIETARY	7,218	8,039	110	10,781	10.00
11.00	01100	CAFETERIA	1,972	0	48	0	30,297
13.00	01300	NURSING ADMINISTRATION	3,219	0	56	0	1,817
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	68	0	766
15.00	01500	PHARMACY	1,562	0	32	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,301	0	41	0	1,958
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,437	142,757	1,684	8,395	5,882
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	208	1,618	1,773
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,068	12,015	22	768	806
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,274	126,819	473	0	3,937
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,716	70	0	115
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,720	51,328	247	0	2,609
57.00	05700	CT SCAN	438	0	0	0	282
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	193
59.00	05900	CARDIAC CATHETERIZATION	3,334	1,674	1	0	23
60.00	06000	LABORATORY	8,028	892	105	0	3,236
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,355	0	92	0	790
66.00	06600	PHYSICAL THERAPY	1,105	15,534	626	0	744
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	1,281
69.00	06900	ELECTROCARDIOLOGY	0	0	10	0	232
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03021	CARDIAC REHABILITATION	0	0	0	0	215
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	10,403	126,355	349	0	3,638
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	57	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	132,060	549,160	4,299	10,781	30,297
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350	10	0	0
194.00	07950	MCH	0	0	0	0	0
194.01	07951	RENTAL	0	0	909	0	0
194.02	07952	CMHS	0	0	0	0	0
194.03	07953	MCH	0	0	0	0	0
194.04	07954	WIC	0	19,321	0	0	0
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0
194.06	07956	LIFELINE	0	0	0	0	0
194.07	07957	PHILLIPS HALL	0	5,728	137	0	0
194.08	07958	OB DRS	0	9,465	0	0	0
194.09	07959	THE WATERS	0	123,010	0	0	0
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)	5,371,346	537,669	1,145,366	1,107,347	421,441
203.00		Unit cost multiplier (Wkst. B, Part I)	40.365119	0.760457	213.887208	102.712828	13.910321
204.00		Cost to be allocated (per Wkst. B, Part II)	1,503,371	114,870	86,373	244,845	68,333
205.00		Unit cost multiplier (Wkst. B, Part II)	11.297680	0.162467	16.129412	22.710787	2.255438

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	17,156				13.00
14.00	01400	0	5,664,839			14.00
15.00	01500	0	12,554	100		15.00
16.00	01600	0	1,699	0	2,663	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	5,882	171,341	0	441	30.00
31.00	03100	1,773	50,166	0	181	31.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	806	0	0	44	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	3,937	452,624	0	615	50.00
52.00	05200	115	0	0	0	52.00
54.00	05400	0	233,323	0	248	54.00
57.00	05700	0	52,346	0	63	57.00
58.00	05800	0	17,897	0	47	58.00
59.00	05900	0	44,078	0	5	59.00
60.00	06000	0	714,453	0	322	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	790	7,345	0	32	65.00
66.00	06600	0	36,240	0	26	66.00
68.00	06800	0	469	0	1	68.00
69.00	06900	0	7,214	0	32	69.00
71.00	07100	0	437,106	0	107	71.00
72.00	07200	0	3,097,051	0	87	72.00
73.00	07300	0	0	100	0	73.00
76.00	03021	215	1,384	0	3	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
91.00	09100	3,638	313,798	0	381	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	8,106	0	11	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
114.00	11400					114.00
116.00	11600	0	5,645	0	17	116.00
118.00		17,156	5,664,839	100	2,663	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
194.08	07958	0	0	0	0	194.08
194.09	07959	0	0	0	0	194.09
200.00						200.00
201.00						201.00
202.00		2,921,121	1,429,395	3,459,244	2,058,933	202.00
203.00		170.268186	0.252328	34,592.440000	773.162974	203.00
204.00		140,284	246,118	87,965	196,801	204.00
205.00		8.176964	0.043447	879.650000	73.901990	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150030

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

			Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,977,028		9,977,028	0	9,977,028	9,638,952	30.00
31.00	03100	INTENSIVE CARE UNIT	3,338,545		3,338,545	0	3,338,545	3,639,911	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	1,377,437		1,377,437	0	1,377,437	633,906	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,740,392		6,740,392	0	6,740,392	5,676,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	269,171		269,171	0	269,171	586,779	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,134,305		4,134,305	0	4,134,305	1,619,341	54.00
57.00	05700	CT SCAN	637,866		637,866	0	637,866	1,751,425	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	474,875		474,875	0	474,875	196,886	58.00
59.00	05900	CARDIAC CATHETERIZATION	934,858		934,858	0	934,858	11,128	59.00
60.00	06000	LABORATORY	5,460,475		5,460,475	8,455	5,468,930	5,127,667	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,152,819	0	1,152,819	0	1,152,819	2,169,487	65.00
66.00	06600	PHYSICAL THERAPY	2,175,039	0	2,175,039	0	2,175,039	600,075	66.00
68.00	06800	SPEECH PATHOLOGY	125,615	0	125,615	0	125,615	12,700	68.00
69.00	06900	ELECTROCARDIOLOGY	257,041		257,041	0	257,041	825,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	732,400		732,400	0	732,400	4,860,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,670,425		4,670,425	0	4,670,425	7,906,419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,459,244		3,459,244	0	3,459,244	13,935,086	73.00
76.00	03021	CARDIAC REHABILITATION	237,382		237,382	0	237,382	594	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00	09100	EMERGENCY	6,231,148		6,231,148	0	6,231,148	866,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,227,712		1,227,712	0	1,227,712	275,816	92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	969,265		969,265		969,265	0	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
116.00	11600	HOSPICE							116.00
200.00		Subtotal (see instructions)	55,424,232	0	55,424,232	8,455	55,432,687	60,333,891	200.00
201.00		Less Observation Beds	1,227,712		1,227,712		1,227,712		201.00
202.00		Total (see instructions)	54,196,520	0	54,196,520	8,455	54,204,975	60,333,891	202.00
Charges									
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00					9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		9,638,952					30.00
31.00	03100	INTENSIVE CARE UNIT		3,639,911					31.00
41.00	04100	SUBPROVIDER - I RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		633,906					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	16,254,426	21,930,906	0.307347	0.000000	0.307347		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	573,899	1,160,678	0.231908	0.000000	0.231908		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,152,417	15,771,758	0.262133	0.000000	0.262133		54.00
57.00	05700	CT SCAN	15,891,894	17,643,319	0.036153	0.000000	0.036153		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,165,575	5,362,461	0.088555	0.000000	0.088555		58.00
59.00	05900	CARDIAC CATHETERIZATION	575,660	586,788	1.593178	0.000000	1.593178		59.00
60.00	06000	LABORATORY	14,918,615	20,046,282	0.272393	0.000000	0.272815		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	1,443,137	3,612,624	0.319108	0.000000	0.319108		65.00
66.00	06600	PHYSICAL THERAPY	2,330,823	2,930,898	0.742107	0.000000	0.742107		66.00
68.00	06800	SPEECH PATHOLOGY	105,051	117,751	1.066785	0.000000	1.066785		68.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150030

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			Outpatient	Total (col. 6 + col. 7)					
			7.00	8.00	9.00	10.00	11.00		
69.00	06900	ELECTROCARDIOLOGY	2,862,939	3,688,029	0.069696	0.000000	0.069696		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,348,382	12,208,397	0.059991	0.000000	0.059991		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,035,116	9,941,535	0.469789	0.000000	0.469789		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,476,998	21,412,084	0.161556	0.000000	0.161556		73.00
76.00	03021	CARDIAC REHABILITATION	304,337	304,931	0.778478	0.000000	0.778478		76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
91.00	09100	EMERGENCY	13,132,268	13,998,402	0.445133	0.000000	0.445133		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	998,348	1,274,164	0.963543	0.000000	0.963543		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	1,254,503	1,254,503					101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
116.00	11600	HOSPICE	1,893,060	1,893,060					116.00
200.00		Subtotal (see instructions)	108,717,448	169,051,339					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	108,717,448	169,051,339					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150030

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

Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,977,028		9,977,028	0	0	9,638,952	30.00
31.00	03100	INTENSIVE CARE UNIT	3,338,545		3,338,545	0	0	3,639,911	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	1,377,437		1,377,437	0	0	633,906	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,740,392		6,740,392	0	0	5,676,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	269,171		269,171	0	0	586,779	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,134,305		4,134,305	0	0	1,619,341	54.00
57.00	05700	CT SCAN	637,866		637,866	0	0	1,751,425	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	474,875		474,875	0	0	196,886	58.00
59.00	05900	CARDIAC CATHETERIZATION	934,858		934,858	0	0	11,128	59.00
60.00	06000	LABORATORY	5,460,475		5,460,475	0	0	5,127,667	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,152,819	0	1,152,819	0	0	2,169,487	65.00
66.00	06600	PHYSICAL THERAPY	2,175,039	0	2,175,039	0	0	600,075	66.00
68.00	06800	SPEECH PATHOLOGY	125,615	0	125,615	0	0	12,700	68.00
69.00	06900	ELECTROCARDIOLOGY	257,041		257,041	0	0	825,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	732,400		732,400	0	0	4,860,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,670,425		4,670,425	0	0	7,906,419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,459,244		3,459,244	0	0	13,935,086	73.00
76.00	03021	CARDIAC REHABILITATION	237,382		237,382	0	0	594	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00	09100	EMERGENCY	6,231,148		6,231,148	0	0	866,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,227,712		1,227,712	0	0	275,816	92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	969,265		969,265		0	0	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
116.00	11600	HOSPICE							116.00
200.00		Subtotal (see instructions)	55,424,232	0	55,424,232	0	0	60,333,891	200.00
201.00		Less Observation Beds	1,227,712		1,227,712		0	0	201.00
202.00		Total (see instructions)	54,196,520	0	54,196,520	0	0	60,333,891	202.00
Charges									
Cost Center Description	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	7.00	8.00	9.00	10.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		9,638,952					30.00
31.00	03100	INTENSIVE CARE UNIT		3,639,911					31.00
41.00	04100	SUBPROVIDER - I RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		633,906					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	16,254,426	21,930,906	0.307347	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	573,899	1,160,678	0.231908	0.000000	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,152,417	15,771,758	0.262133	0.000000	0.000000		54.00
57.00	05700	CT SCAN	15,891,894	17,643,319	0.036153	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,165,575	5,362,461	0.088555	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	575,660	586,788	1.593178	0.000000	0.000000		59.00
60.00	06000	LABORATORY	14,918,615	20,046,282	0.272393	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	1,443,137	3,612,624	0.319108	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,330,823	2,930,898	0.742107	0.000000	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	105,051	117,751	1.066785	0.000000	0.000000		68.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150030

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

Worksheet C
Part I
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Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost
			Outpatient	Total (col. 6 + col. 7)				
			7.00	8.00	9.00	10.00	11.00	
69.00	06900	ELECTROCARDIOLOGY	2,862,939	3,688,029	0.069696	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,348,382	12,208,397	0.059991	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,035,116	9,941,535	0.469789	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,476,998	21,412,084	0.161556	0.000000	0.000000	73.00
76.00	03021	CARDIAC REHABILITATION	304,337	304,931	0.778478	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	13,132,268	13,998,402	0.445133	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	998,348	1,274,164	0.963543	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,254,503	1,254,503				101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,893,060	1,893,060				116.00
200.00		Subtotal (see instructions)	108,717,448	169,051,339				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	108,717,448	169,051,339				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/30/2013 3:52 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,360,597	0	1,360,597	9,573	142.13	30.00
31.00	INTENSIVE CARE UNIT	478,289		478,289	1,618	295.61	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	141,580		141,580	768	184.35	43.00
200.00	Total (lines 30-199)	1,980,466		1,980,466	11,959		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,746	674,549				
31.00	INTENSIVE CARE UNIT	1,078	318,668				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	5,824	993,217				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/30/2013 3:52 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	711,266	21,930,906	0.032432	2,605,615	84,505	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54,831	1,160,678	0.047240	898	42	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	461,975	15,771,758	0.029291	1,146,572	33,584	54.00
57.00	05700 CT SCAN	27,890	17,643,319	0.001581	1,527,743	2,415	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	26,498	5,362,461	0.004941	134,745	666	58.00
59.00	05900 CARDIAC CATHETERIZATION	118,696	586,788	0.202281	11,128	2,251	59.00
60.00	06000 LABORATORY	374,885	20,046,282	0.018701	3,303,543	61,780	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	98,265	3,612,624	0.027200	1,158,762	31,518	65.00
66.00	06600 PHYSICAL THERAPY	75,657	2,930,898	0.025814	386,144	9,968	66.00
68.00	06800 SPEECH PATHOLOGY	10,335	117,751	0.087770	10,959	962	68.00
69.00	06900 ELECTROCARDIOLOGY	5,887	3,688,029	0.001596	785,923	1,254	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,711	12,208,397	0.002679	2,659,445	7,125	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	182,166	9,941,535	0.018324	3,845,399	70,463	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	87,965	21,412,084	0.004108	8,776,322	36,053	73.00
76.00	03021 CARDIAC REHABILITATION	19,666	304,931	0.064493	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	493,638	13,998,402	0.035264	539,023	19,008	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	167,427	1,274,164	0.131401	108,489	14,256	92.00
200.00	Total (lines 50-199)	2,949,758	151,991,007		27,000,710	375,850	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/30/2013 3:52 pm	
Title XVIII			Hospital		PPS			
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,573	0.00	4,746	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,618	0.00	1,078	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	768	0.00	0	0		43.00
200.00		Total (lines 30-199)	11,959		5,824	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150030

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2013 3:52 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
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	03021	CARDIAC REHABILITATION	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
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: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 3:52 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	21,930,906	0.000000	0.000000	2,605,615	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,160,678	0.000000	0.000000	898	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,771,758	0.000000	0.000000	1,146,572	54.00
57.00	05700 CT SCAN	0	17,643,319	0.000000	0.000000	1,527,743	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,362,461	0.000000	0.000000	134,745	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	586,788	0.000000	0.000000	11,128	59.00
60.00	06000 LABORATORY	0	20,046,282	0.000000	0.000000	3,303,543	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	3,612,624	0.000000	0.000000	1,158,762	65.00
66.00	06600 PHYSICAL THERAPY	0	2,930,898	0.000000	0.000000	386,144	66.00
68.00	06800 SPEECH PATHOLOGY	0	117,751	0.000000	0.000000	10,959	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,688,029	0.000000	0.000000	785,923	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,208,397	0.000000	0.000000	2,659,445	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	9,941,535	0.000000	0.000000	3,845,399	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,412,084	0.000000	0.000000	8,776,322	73.00
76.00	03021 CARDIAC REHABILITATION	0	304,931	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	13,998,402	0.000000	0.000000	539,023	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,274,164	0.000000	0.000000	108,489	92.00
200.00	Total (lines 50-199)	0	151,991,007			27,000,710	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 3:52 pm
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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 XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,489,615	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	386	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,757,647	0	54.00
57.00	05700 CT SCAN	0	4,277,898	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,242,910	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	249,660	0	59.00
60.00	06000 LABORATORY	0	456,113	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	211,900	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,843,079	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	963,792	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	643,951	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,260,092	0	73.00
76.00	03021 CARDIAC REHABILITATION	0	176,823	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	2,682,477	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	298,752	0	92.00
200.00	Total (lines 50-199)	0	26,555,095	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 3:52 pm
		Title XVIII	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	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.307347	5,489,615	0	0	1,687,217 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.231908	386	0	0	90 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262133	4,757,647	0	0	1,247,136 54.00
57.00	05700 CT SCAN	0.036153	4,277,898	0	0	154,659 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.088555	1,242,910	0	0	110,066 58.00
59.00	05900 CARDIAC CATHETERIZATION	1.593178	249,660	0	0	397,753 59.00
60.00	06000 LABORATORY	0.272393	456,113	0	0	124,242 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.319108	211,900	0	0	67,619 65.00
66.00	06600 PHYSICAL THERAPY	0.742107	0	0	0	0 66.00
68.00	06800 SPEECH PATHOLOGY	1.066785	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.069696	1,843,079	0	0	128,455 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.059991	963,792	542	0	57,819 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.469789	643,951	0	0	302,521 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.161556	3,260,092	0	14,780	526,687 73.00
76.00	03021 CARDIAC REHABILITATION	0.778478	176,823	0	0	137,653 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
91.00	09100 EMERGENCY	0.445133	2,682,477	0	0	1,194,059 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.963543	298,752	0	0	287,860 92.00
200.00	Subtotal (see instructions)		26,555,095	542	14,780	6,423,836 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		26,555,095	542	14,780	6,423,836 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 3:52 pm
	Title XVIII	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		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
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	33	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,388		73.00
76.00 03021 CARDIAC REHABILITATION	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	33	2,388		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	33	2,388		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2013 3:52 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,573	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,573	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)		8,395	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)		4,746	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,977,028	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)		9,977,028	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,638,952	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,638,952	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.035074	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)		1,148.18	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)		9,977,028	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,042.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,946,281	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,946,281	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 3:52 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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	3,338,545	1,618	2,063.38	1,078	2,224,324	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)					6,538,943	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,709,548	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)					993,217	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					375,850	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,369,067	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,340,481	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)					1,178	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,042.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,227,712	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 3:52 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,360,597	9,977,028	0.136373	1,227,712	167,427	90.00
91.00	Nursing School cost	0	9,977,028	0.000000	1,227,712	0	91.00
92.00	Allied health cost	0	9,977,028	0.000000	1,227,712	0	92.00
93.00	All other Medical Education	0	9,977,028	0.000000	1,227,712	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2013 3:52 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,573	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,573	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)		8,395	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)		566	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)		768	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,977,028	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)		9,977,028	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,638,952	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,638,952	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.035074	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)		1,148.18	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)		9,977,028	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,042.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		589,885	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)		589,885	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Date/Time Prepared: 5/30/2013 3:52 pm		Title XIX		Hospital		Cost	
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)	1,377,437	768	1,793.54	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,338,545	1,618	2,063.38	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					407,213	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					997,098	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,178	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,042.20	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,227,712	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 3:52 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 3:52 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		5,123,768		30.00
31.00	03100 INTENSIVE CARE UNIT		2,270,546		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.307347	2,605,615	800,828	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.231908	898	208	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262133	1,146,572	300,554	54.00
57.00	05700 CT SCAN	0.036153	1,527,743	55,232	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.088555	134,745	11,932	58.00
59.00	05900 CARDIAC CATHETERIZATION	1.593178	11,128	17,729	59.00
60.00	06000 LABORATORY	0.272815	3,303,543	901,256	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.319108	1,158,762	369,770	65.00
66.00	06600 PHYSICAL THERAPY	0.742107	386,144	286,560	66.00
68.00	06800 SPEECH PATHOLOGY	1.066785	10,959	11,691	68.00
69.00	06900 ELECTROCARDIOLOGY	0.069696	785,923	54,776	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.059991	2,659,445	159,543	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.469789	3,845,399	1,806,526	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.161556	8,776,322	1,417,867	73.00
76.00	03021 CARDIAC REHABILITATION	0.778478	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.445133	539,023	239,937	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.963543	108,489	104,534	92.00
200.00	Total (sum of lines 50-94 and 96-98)		27,000,710	6,538,943	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		27,000,710		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 3:52 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		841,280		30.00
31.00	03100 INTENSIVE CARE UNIT		112,552		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		203,765		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.307347	285,532	87,757	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.231908	146,562	33,989	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.262133	46,719	12,247	54.00
57.00	05700 CT SCAN	0.036153	20,256	732	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.088555	19,885	1,761	58.00
59.00	05900 CARDIAC CATHETERIZATION	1.593178	0	0	59.00
60.00	06000 LABORATORY	0.272393	289,353	78,818	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.319108	92,775	29,605	65.00
66.00	06600 PHYSICAL THERAPY	0.742107	14,827	11,003	66.00
68.00	06800 SPEECH PATHOLOGY	1.066785	353	377	68.00
69.00	06900 ELECTROCARDIOLOGY	0.069696	32,802	2,286	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.059991	449,884	26,989	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.469789	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.161556	752,981	121,649	73.00
76.00	03021 CARDIAC REHABILITATION	0.778478	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.445133	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.963543	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,151,929	407,213	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,151,929		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/30/2013 3:52 pm
		Title VIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		8,071,889	1.00
2.00	Outlier payments for discharges. (see instructions)		252,188	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		86.78	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.86	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		16.52	31.00
32.00	Sum of lines 30 and 31		21.38	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.85	33.00
34.00	Disproportionate share adjustment (see instructions)		552,924	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		8,877,001	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		10,279,654	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		9,928,991	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		673,807	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/30/2013 3:52 pm
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			10,602,798 59.00
60.00	Primary payer payments			8,455 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			10,594,343 61.00
62.00	Deductibles billed to program beneficiaries			1,062,076 62.00
63.00	Coinurance billed to program beneficiaries			11,560 63.00
64.00	Allowable bad debts (see instructions)			-45,410 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			-31,787 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-55,211 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9,488,920 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			1,715 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			9,490,635 71.00
72.00	Interim payments			9,442,184 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			48,451 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			60,000 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/30/2013 3:52 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,421	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,423,836	2.00
3.00	PPS payments		6,162,160	3.00
4.00	Outlier payment (see instructions)		9,127	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.859	5.00
6.00	Line 2 times line 5		5,518,075	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)		2,421	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		15,322	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)		15,322	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		15,322	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,901	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)		2,421	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)		6,171,287	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		108	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,506,962	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		4,666,638	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,666,638	30.00
31.00	Primary payer payments		2,160	31.00
32.00	Subtotal (line 30 minus line 31)		4,664,478	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		78,464	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		54,925	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,154	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,719,403	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		4,719,403	40.00
41.00	Interim payments		4,852,367	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)		-132,964	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150030

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2013 3:52 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,273,561		4,662,814	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	12/31/2012	168,623	12/31/2012	189,553	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)		168,623		189,553	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)		9,442,184		4,852,367	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		48,451		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		132,964	6.02	
7.00	Total Medicare program liability (see instructions)		9,490,635		4,719,403	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: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/30/2013 3:52 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		2,621	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		5,824	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		162	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		10,013	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		169,051,339	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		3,459,318	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,400,314	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		1,569,424	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)		-169,110	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2013 3:52 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		997,098		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		997,098	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		997,098	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,157,597		8.00
9.00	Ancillary service charges		2,151,929	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		3,309,526	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,309,526	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,312,428	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		997,098	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		997,098	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		997,098	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		997,098	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		997,098	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		997,098	0	40.00
41.00	Interim payments		1,534,239	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-537,141	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 150030

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

Worksheet G

Date/Time Prepared:
5/30/2013 3:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,527,423	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	6,631,496	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,112,065	0	0	0	9.00
10.00	Due from other funds	21,122,010	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,392,994	0	0	0	11.00
FIXED ASSETS						
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	1,621,597	0	0	0	13.00
14.00	Accumulated depreciation	-1,547,202	0	0	0	14.00
15.00	Buildings	36,152,013	0	0	0	15.00
16.00	Accumulated depreciation	-25,805,296	0	0	0	16.00
17.00	Leasehold improvements	2,434,465	0	0	0	17.00
18.00	Accumulated depreciation	-694,727	0	0	0	18.00
19.00	Fixed equipment	14,719,456	0	0	0	19.00
20.00	Accumulated depreciation	-12,792,666	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	31,585,366	0	0	0	23.00
24.00	Accumulated depreciation	-20,753,961	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,965,045	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	23,780,883	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	23,780,883	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	89,138,922	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,581,158	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,717,078	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,073,149	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,371,385	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,682,625	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,682,625	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,054,010	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	61,084,912				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)	61,084,912	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	89,138,922	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150030

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

Worksheet G-1

Date/Time Prepared:
5/30/2013 3:52 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		52,424,965		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,640,846			2.00
3.00	Total (sum of line 1 and line 2)		59,065,811		0	3.00
4.00	RELATED PARTY-CATH LAB	3,588,445		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)		3,588,445		0	10.00
11.00	Subtotal (line 3 plus line 10)		62,654,256		0	11.00
12.00	RELATED PARTY LOSSES	1,569,344		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)		1,569,344		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		61,084,912		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	RELATED PARTY-CATH LAB		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	RELATED PARTY LOSSES		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150030

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,638,952		9,638,952	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	9,638,952		9,638,952	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,639,911		3,639,911	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)	3,639,911		3,639,911	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,278,863		13,278,863	17.00
18.00	Ancillary services	45,279,172	91,439,269	136,718,441	18.00
19.00	Outpatient services	1,141,950	14,130,616	15,272,566	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		1,254,503	1,254,503	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,893,060	1,893,060	26.00
27.00	NURSERY	633,906	0	633,906	27.00
27.01	PROFESSIONAL FEES	5,196	1,327,497	1,332,693	27.01
27.02	OTHER	0	7,258	7,258	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	60,339,087	110,052,203	170,391,290	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,480,685		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)		63,480,685		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150030

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

Worksheet G-3

Date/Time Prepared:
5/30/2013 3:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	170,391,290	1.00
2.00	Less contractual allowances and discounts on patients' accounts	106,965,088	2.00
3.00	Net patient revenues (line 1 minus line 2)	63,426,202	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,480,685	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-54,483	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	6,718,021	24.00
25.00	Total other income (sum of lines 6-24)	6,718,021	25.00
26.00	Total (line 5 plus line 25)	6,663,538	26.00
27.00	NONOPERATING EXPENSE	22,692	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	22,692	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,640,846	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet H

HHA CCN: 157430

To 12/31/2012

Date/Time Prepared: 5/30/2013 3:52 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	78,439	0	0	132,860	211,299	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	215,348	0	0	0	215,348	6.00
7.00	Physical Therapy	149,026	0	0	0	149,026	7.00
8.00	Occupational Therapy	24,414	0	0	0	24,414	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	20,993	0	0	0	20,993	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	488,220	0	0	132,860	621,080	24.00
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
		7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	211,299	-7,408	203,891		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	215,348	0	215,348		6.00
7.00	Physical Therapy	0	149,026	0	149,026		7.00
8.00	Occupational Therapy	0	24,414	0	24,414		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	20,993	0	20,993		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
24.00	Total (sum of lines 1-23)	0	621,080	-7,408	613,672		24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet H-1 Part I Date/Time Prepared: 5/30/2013 3:52 pm
		HHA CCN: 157430	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	203,891	0	0	0	203,891	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	215,348	0	0	0	215,348	6.00	
7.00	Physical Therapy	149,026	0	0	0	149,026	7.00	
8.00	Occupational Therapy	24,414	0	0	0	24,414	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	20,993	0	0	0	20,993	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	613,672	0	0	0	613,672	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	203,891					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	107,149	322,497				6.00	
7.00	Physical Therapy	74,150	223,176				7.00	
8.00	Occupational Therapy	12,147	36,561				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	10,445	31,438				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		613,672				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150030
HHA CCN: 157430

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

Worksheet H-1
Part II
Date/Time Prepared:
5/30/2013 3:52 pm
PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-203,891	409,781
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	215,348
7.00	Physical Therapy	0	0	0	0	0	149,026
8.00	Occupational Therapy	0	0	0	0	0	24,414
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	20,993
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-203,891	409,781
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		203,891
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.497561

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150030

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

Worksheet H-2 Part I

HHA CCN: 157430

Date/Time Prepared: 5/30/2013 3:52 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT	NEW MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	0	0	153,379	153,379	35,887	1.00	
2.00 Skilled Nursing Care	322,497	0	0	0	322,497	75,457	2.00	
3.00 Physical Therapy	223,176	0	0	0	223,176	52,218	3.00	
4.00 Occupational Therapy	36,561	0	0	0	36,561	8,554	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	31,438	0	0	0	31,438	7,356	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	613,672	0	0	153,379	767,051	179,472	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	0	12,192	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	0	12,192	0	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150030

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

Worksheet H-2 Part I

HHA CCN: 157430

Date/Time Prepared: 5/30/2013 3:52 pm

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	2,045	0	8,505	212,008	0	212,008	1.00
2.00	Skilled Nursing Care	0	0	0	397,954	0	397,954	2.00
3.00	Physical Therapy	0	0	0	275,394	0	275,394	3.00
4.00	Occupational Therapy	0	0	0	45,115	0	45,115	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	38,794	0	38,794	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	2,045	0	8,505	969,265	0	969,265	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	111,414	509,368					2.00
3.00	Physical Therapy	77,102	352,496					3.00
4.00	Occupational Therapy	12,631	57,746					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	10,861	49,655					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	212,008	969,265					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.279968						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150030
HHA CCN: 157430

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

Worksheet H-2
Part II
Date/Time Prepared:
5/30/2013 3:52 pm
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	0	0	488,220	0	153,379	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	322,497	0	2.00
3.00 Physical Therapy	0	0	0	0	223,176	0	3.00
4.00 Occupational Therapy	0	0	0	0	36,561	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	31,438	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	488,220	0	767,051	0	20.00
21.00 Total cost to be allocated	0	0	153,379	0	179,472	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.314160		0.233977	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	57	0	0	0	8,106	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	57	0	0	0	8,106	20.00
21.00 Total cost to be allocated	0	12,192	0	0	0	2,045	21.00
22.00 Unit cost multiplier	0.000000	213.894737	0.000000	0.000000	0.000000	0.252282	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150030
HHA CCN: 157430

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

Worksheet H-2
Part II
Date/Time Prepared:
5/30/2013 3:52 pm
PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
	15.00	16.00		
1.00 Administrative and General	0	11		1.00
2.00 Skilled Nursing Care	0	0		2.00
3.00 Physical Therapy	0	0		3.00
4.00 Occupational Therapy	0	0		4.00
5.00 Speech Pathology	0	0		5.00
6.00 Medical Social Services	0	0		6.00
7.00 Home Health Aide	0	0		7.00
8.00 Supplies (see instructions)	0	0		8.00
9.00 Drugs	0	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
20.00 Total (sum of lines 1-19)	0	11		20.00
21.00 Total cost to be allocated	0	8,505		21.00
22.00 Unit cost multiplier	0.000000	773.181818		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part I Date/Time Prepared: 5/30/2013 3:52 pm		
				Title XVIII	Home Health Agency I	PPS		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	509,368		509,368	2,373	214.65	1.00
2.00	Physical Therapy	3.00	352,496	0	352,496	2,281	154.54	2.00
3.00	Occupational Therapy	4.00	57,746	0	57,746	418	138.15	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	49,655		49,655	794	62.54	6.00
7.00	Total (sum of lines 1-6)		969,265	0	969,265	5,866		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99915	812	556			8.00
9.00	Physical Therapy		99915	727	667			9.00
10.00	Occupational Therapy		99915	71	176			10.00
11.00	Speech Pathology		99915	0	0			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	152	227			13.00
14.00	Total (sum of lines 8-13)			1,762	1,626			14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A			Cost of Services				
	6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	812	556		174,296	119,345		1.00
2.00	Physical Therapy	727	667		112,351	103,078		2.00
3.00	Occupational Therapy	71	176		9,809	24,314		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	152	227		9,506	14,197		6.00
7.00	Total (sum of lines 1-6)	1,762	1,626		305,962	260,934		7.00
Cost Center Description								
	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150030 HHA CCN: 157430		Period: From 01/01/2012 To 12/31/2012		Worksheet H-3 Part I Date/Time Prepared: 5/30/2013 3:52 pm		
				Title XVII I		Home Health Agency I		
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance			Not Subject to Deductibles & Co Insurance		Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies						15.00	
16.00	Cost of Drugs		120	0		0	16.00	
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	293,641					1.00	
2.00	Physical Therapy	215,429					2.00	
3.00	Occupational Therapy	34,123					3.00	
4.00	Speech Pathology	0					4.00	
5.00	Medical Social Services	0					5.00	
6.00	Home Health Aide	23,703					6.00	
7.00	Total (sum of lines 1-6)	566,896					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part II Date/Time Prepared: 5/30/2013 3:52 pm PPS
		Title XVIII	Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.742107	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy			0	0	col. 2, line 2.00 2.00
3.00	Speech Pathology	68.00	1.066785	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.059991	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.161556	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-11 Date/Time Prepared: 5/30/2013 3:52 pm	
		Title XVII I	Home Health Agency I	PPS	
		Part A	Part B	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)		0	0	0 1.00
2.00	Total charges		0	0	0 2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	0 3.00
4.00	Amount 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(b)		0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)		0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)		0	0	0 8.00
9.00	Primary payer amounts		0	0	0 9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		282,396	268,480	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		11,526	5,720	13.00
14.00	Total PPS Reimbursement - PEP Episodes		3,176	1,368	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)				0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		297,098	275,568	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		297,098	275,568	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		297,098	275,568	26.00
27.00	Reimbursable bad debts (from your records)		0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2013 3:52 pm	
		Title XVIII	Home Health Agency I	PPS	
				Part A Services	Part B Services
				1.00	2.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		297,098	275,568	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1	120	30.00
31.00	Subtotal (line 29 plus/minus line 30)		297,099	275,688	31.00
32.00	Interim payments (see instructions)		297,099	275,688	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150030	Period: From 01/01/2012	Worksheet H-5
	HHA CCN: 157430	To 12/31/2012	
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		297,099		275,688	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			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			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. H-4, Part II, column as appropriate, line 32)		297,099		275,688	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		297,099		275,688	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/30/2013 3:52 pm PPS
			Home Health Agency I	
			Contractor Number	Date (Mo/Day/Yr)
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K

Hospice CCN: 151564

To 12/31/2012

Date/Time Prepared: 5/30/2013 3:52 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	74,991	0	0	0	309,877	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	8,394	0	0	0	0	9.00
10.00	Nursing Care	156,857	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	30,419	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	24,983	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	295,644	0	0	0	309,877	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K

Hospice CCN: 151564

To 12/31/2012

Date/Time Prepared: 5/30/2013 3:52 pm

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	384,868	-28,516	356,352	0	356,352	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	8,394	0	8,394	0	8,394	9.00
10.00	Nursing Care	156,857	0	156,857	0	156,857	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	30,419	0	30,419	0	30,419	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	24,983	0	24,983	0	24,983	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	605,521	-28,516	577,005	0	577,005	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-1

Hospice CCN: 151564

To 12/31/2012

Date/Time Prepared: 5/30/2013 3:52 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	74,991	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	156,857	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	30,419	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	74,991	0	30,419	0	156,857	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-1

Hospice CCN: 151564

To 12/31/2012

Date/Time Prepared: 5/30/2013 3:52 pm

		Hospice I			
		Total Therapists	Aides	All-Other	Total (1)
		6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance		0	0	3.00
4.00	Transportation - Staff		0	0	4.00
5.00	Volunteer Service Coordination		0	0	5.00
6.00	Administrative and General		0	0	6.00
INPATIENT CARE SERVICE					
7.00	Inpatient - General Care		0	0	7.00
8.00	Inpatient - Respite Care		0	0	8.00
VISITING SERVICES					
9.00	Physician Services		0	8,394	9.00
10.00	Nursing Care		0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services		0	0	15.00
16.00	Spiritual Counseling		0	0	16.00
17.00	Dietary Counseling		0	0	17.00
18.00	Counseling - Other		0	0	18.00
19.00	Home Health Aide and Homemaker		24,983	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	20.00
21.00	Other		0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy				22.00
23.00	Analgesics				23.00
24.00	Sedatives / Hypnotics				24.00
25.00	Other - Specify				25.00
26.00	Durable Medical Equipment/Oxygen				26.00
27.00	Patient Transportation		0	0	27.00
28.00	Imaging Services		0	0	28.00
29.00	Labs and Diagnostics		0	0	29.00
30.00	Medical Supplies		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	31.00
32.00	Radiation Therapy		0	0	32.00
33.00	Chemotherapy		0	0	33.00
34.00	Other		0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs		0	0	35.00
36.00	Volunteer Program Costs		0	0	36.00
37.00	Fundraising		0	0	37.00
38.00	Other Program Costs		0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	24,983	8,394	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150030
 Hospice CCN: 151564

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 5/30/2013 3:52 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	356,352	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	8,394	0	0	0	0	9.00
10.00	Nursing Care	156,857	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	30,419	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	24,983	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	577,005	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet K-4 Part I Date/Time Prepared: 5/30/2013 3:52 pm		
		Hospice CCN: 151564		Hospice I		
		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	356,352	356,352		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	8,394	13,556	21,950	9.00
10.00	Nursing Care	0	156,857	253,323	410,180	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	30,419	49,126	79,545	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	24,983	40,347	65,330	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	577,005		577,005	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-4

Hospice CCN: 151564

To 12/31/2012

Part II
Date/Time Prepared:
5/30/2013 3:52 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030
 Hospice CCN: 151564

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 5/30/2013 3:52 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-356,352	220,653	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	8,394	9.00
10.00	Nursing Care	0	156,857	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	30,419	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	24,983	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		356,352	39.00
40.00	Unit Cost Multiplier		1.614988	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151564

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General		0	0	92,880	92,880	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	21,950	0	0	0	21,950	4.00
5.00 Nursing Care	410,180	0	0	0	410,180	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	79,545	0	0	0	79,545	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	65,330	0	0	0	65,330	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	577,005	0	0	92,880	669,885	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period:

Worksheet K-5

Hospice CCN: 151564

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

Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	21,732	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	5,136	0	0	0	0	4.00
5.00	Nursing Care	95,971	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	18,612	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	15,286	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	156,737	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151564

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	1,424	0	13,144	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	1,424	0	13,144	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151564

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	129,180					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	27,086	0	27,086	4,914	32,000	4.00
5.00	Nursing Care	506,151	0	506,151	91,831	597,982	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	98,157	0	98,157	17,809	115,966	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	80,616	0	80,616	14,626	95,242	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	841,190	0	841,190		841,190	34.00
35.00	Unit Cost Multiplier (see instructions)				0.181430		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150030
Hospice CCN: 151564

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
1.00	Administrative and General	0	0	295,644	0	92,880	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	21,950	4.00
5.00	Nursing Care	0	0	0	0	410,180	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	79,545	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	65,330	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	295,644		669,885	34.00
35.00	Total cost to be allocated	0	0	92,880		156,737	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.314162		0.233976	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150030
Hospice CCN: 151564

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	Hospice I						
	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)		
	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	0	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	0	34.00
35.00 Total cost to be allocated	0	0	0	0	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150030
Hospice CCN: 151564

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2013 3:52 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY			
	(DIRECT NURSING HRS)	(COSTED REQUIS.)		(TIME SPENT)			
	13.00	14.00	15.00	16.00			
1.00 Administrative and General	0	5,645	0	17		1.00	
2.00 Inpatient - General Care	0	0	0	0		2.00	
3.00 Inpatient - Respite Care	0	0	0	0		3.00	
4.00 Physician Services	0	0	0	0		4.00	
5.00 Nursing Care	0	0	0	0		5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00	
7.00 Physical Therapy	0	0	0	0		7.00	
8.00 Occupational Therapy	0	0	0	0		8.00	
9.00 Speech/ Language Pathology	0	0	0	0		9.00	
10.00 Medical Social Services	0	0	0	0		10.00	
11.00 Spiritual Counseling	0	0	0	0		11.00	
12.00 Dietary Counseling	0	0	0	0		12.00	
13.00 Counseling - Other	0	0	0	0		13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00	
16.00 Other	0	0	0	0		16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00	
18.00 Analgesics	0	0	0	0		18.00	
19.00 Sedatives / Hypnotics	0	0	0	0		19.00	
20.00 Other - Specify	0	0	0	0		20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00	
22.00 Patient Transportation	0	0	0	0		22.00	
23.00 Imaging Services	0	0	0	0		23.00	
24.00 Labs and Diagnostics	0	0	0	0		24.00	
25.00 Medical Supplies	0	0	0	0		25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00	
27.00 Radiation Therapy	0	0	0	0		27.00	
28.00 Chemotherapy	0	0	0	0		28.00	
29.00 Other	0	0	0	0		29.00	
30.00 Bereavement Program Costs	0	0	0	0		30.00	
31.00 Volunteer Program Costs	0	0	0	0		31.00	
32.00 Fundraising	0	0	0	0		32.00	
33.00 Other Program Costs	0	0	0	0		33.00	
34.00 Total (sum of lines 1 thru 33) (2)	0	5,645	0	17		34.00	
35.00 Total cost to be allocated	0	1,424	0	13,144		35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.252259	0.000000	773.176471		36.00	

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150030 Hospice CCN: 151564	Period: From 01/01/2012 To 12/31/2012	Worksheet K-5 Part III Date/Time Prepared: 5/30/2013 3:52 pm		
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.742107	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00	1.066785	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.161556	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.272815	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.059991	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	CARDIAC REHABILITATION	76.00	0.778478	0	0	10.00
11.00	Totals (sum of lines 1-10)					0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150030

Period: From 01/01/2012

Worksheet K-6

Hospice CCN: 151564

To 12/31/2012

Date/Time Prepared: 5/30/2013 3:52 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				841,190	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,894	2.00
3.00	Average cost per diem (line 1 divided by line 2)				171.88	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,021				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	691,129				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		228			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		39,189			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	355				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	61,017				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			645		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			110,863		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150030	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/30/2013 3:52 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		647,567	1.00
2.00	Capital DRG outlier payments		26,240	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		27.36	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		673,807	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00