

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: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 12:28 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: 5/29/2013 Time: 12:28 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 PUTNAM COUNTY HOSPITAL ( 151333 ) 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 XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	494,148	35,893	221,804	-93,058	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	143,385	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	637,533	35,893	221,804	-93,058	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.

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 OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 12:28 pm
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**Encryption Information**

**ECR:** Date: 5/29/2013 Time: 12:28 pm  
 qWVTqmvAiITGIrP94iR5e03EFXUs70  
 SdPuFOZZKpIs: kd0CZRXCIFVGMJ3I  
 e6XlOLmk2l0e0o5N  
**PI:** Date: 5/29/2013 Time: 12:28 pm  
 ymQi wGPI dNQqE7RrkzXkR7M1qsU7g0  
 a95Ko0FFa8MBS5NP: fxG7i d99sgB1Q  
 NTdG06snEG071cnJ

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	494,148	35,893	221,804	-93,058	1.00
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4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	143,385	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	637,533	35,893	221,804	-93,058	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 12:24 pm				
1.00		2.00		3.00		4.00				
<b>Hospital and Hospital Health Care Complex Address:</b>										
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:							1.00	
2.00	City: GREENCASTLE	State: IN		Zip Code: 46135-		County: PUTNAM			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	
		V	XVIII	XIX						
<b>Hospital and Hospital-Based Component Identification:</b>										
3.00	Hospital	PUTNAM COUNTY HOSPITAL	151333	99915	1	12/31/2005	N	0	0	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	PUTNAM COUNTY HOSPITAL	152333	99915		12/31/2005	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)					9			21.00	
<b>Inpatient PPS Information</b>										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N			22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural	S	Date of Geogr		
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 12:24 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1 / (col. 1 + col. 2)) 3.00		
<b>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151333

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 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

	Program Name	Program Code	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
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 12:24 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.00	List amounts of malpractice premiums and paid losses:	206,953	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		
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		
		1.00	2.00	3.00	
<b>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.</b>					
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	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
<b>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)</b>					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 12:24 pm		
								1.00	
<b>Multi campus</b>									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
								1.00	
<b>Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act</b>									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							1,508,627	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)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 12:24 pm	
			Y/N	Date	
			1.00	2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>					
<b>COMPLETED BY ALL HOSPITALS</b>					
<b>Provider Organization and Operation</b>					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
<b>Financial Data and Reports</b>					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	07/01/2013
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
<b>Approved Educational Activities</b>					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
<b>Bad Debts</b>					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	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
<b>Bed Complement</b>					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
<b>PS&amp;R Data</b>					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	04/15/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7946		TSEVERS@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/15/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 5/29/2013 12:24 pm
		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
<b>RCE DI ALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151333

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai l ab l e	CAH Hours	I/P Days / O/P Vi s i t s / 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	19	6,954	55,008.00	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)		19	6,954	55,008.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	6,264.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	61,272.00	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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Vi s i t s / Tri ps			Full Time Equival ents	
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol I
	6.00	7.00	8.00	9.00	10.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,294	74	1,962		1.00
2.00 HMO	359	0			2.00
3.00 HMO IPF Subprovider	0	0			3.00
4.00 HMO IRF Subprovider	0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	569	0	569		5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	140		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,863	74	2,671		7.00
8.00 INTENSIVE CARE UNIT	383	0	572		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	0		13.00
14.00 Total (see instructions)	2,246	74	3,243	0.00	231.00
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
18.00 SUBPROVIDER	0	0	0	0.00	0.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151333

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 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	
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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
27.00	Total (sum of lines 14-26)				0.00	231.00	27.00
28.00	Observation Bed Days		0	720			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
		11.00	12.00	13.00	14.00		15.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	424	26	720	1.00
2.00	HMO			101			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	424	26	720	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/29/2013 12:24 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.441946	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		2,016,607	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		5,649,319	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,496,694	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)		480,087	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		480,087	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	902,587	0	902,587	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	398,895	0	398,895	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)	398,895	0	398,895	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,079,646	6,079,646	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		113,708	113,708	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		5,965,938	5,965,938	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,636,622	2,636,622	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		3,035,517	3,035,517	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,515,604	3,515,604	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151333

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

Worksheet A  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,484,633		2,484,633	1.00
4.00	00400	EMPLOYEE BENEFITS	18,916	2,888,200		2,907,116	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,601,049	3,333,228		4,934,277	5.00
7.00	00700	OPERATION OF PLANT	179,855	946,958		1,126,813	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,792	69,967		88,759	8.00
9.00	00900	HOUSEKEEPING	306,275	37,325		343,600	9.00
10.00	01000	DIETARY	305,096	262,416		567,512	10.00
11.00	01100	CAFETERIA	0	0		0	11.00
13.00	01300	NURSING ADMINISTRATION	362,139	107,022		469,161	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	226,322	377,755		604,077	16.00
17.00	01700	SOCIAL SERVICE	0	0		0	17.00
17.01	01701	UTILIZATION REVIEW	101,762	6,474		108,236	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	900,600	49,096		949,696	30.00
31.00	03100	INTENSIVE CARE UNIT	801,584	43,480		845,064	31.00
41.00	04100	SUBPROVIDER - IRF	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0		0	42.00
43.00	04300	NURSERY	0	0		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	406,448	662,537		1,068,985	50.00
51.00	05100	RECOVERY ROOM	101,980	10,601		112,581	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53.00	05300	ANESTHESIOLOGY	578,619	124,710		703,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	562,131	222,781		784,912	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	120,437		120,437	54.01
57.00	05700	CT SCAN	133,892	274,247		408,139	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	59.00
60.00	06000	LABORATORY	552,769	1,250,270		1,803,039	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	313,602	101,473		415,075	65.00
66.00	06600	PHYSICAL THERAPY	0	456,467		456,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	99,054		99,054	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,266		6,266	68.00
69.00	06900	ELECTROCARDIOLOGY	43,904	93,419		137,323	69.00
69.01	06901	CARDIAC REHAB	73,164	3,506		76,670	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,440	51,726		59,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,336	1,621,785		1,741,121	73.00
73.01	07301	ONCOLOGY	243,229	1,996,604		2,239,833	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.00
90.00	09000	CLINIC	7,657	3,714		11,371	90.00
91.00	09100	EMERGENCY	943,427	1,954,978		2,898,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0		0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		0	110.00
111.00	11100	ISLET ACQUISITION	0	0		0	111.00
113.00	11300	INTEREST EXPENSE	0	0		0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,909,988	19,661,129		28,571,117	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,869,364	939,173		3,808,537	192.00
193.00	19300	NONPAID WORKERS	0	0		0	193.00
193.01	19301	DME	0	0		0	193.01
193.02	19302	LACTATION CONSULTING	0	0		0	193.02
193.03	19303	DIABETIC COUNSELING	0	0		0	193.03
194.00	07950	VACANT SPACE	0	0		0	194.00
194.01	07951	BOARD OF HEALTH	0	0		0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	11,779,352	20,600,302		32,379,654	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151333

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

Worksheet A  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-86,804	2,760,603	1.00
4.00	00400 EMPLOYEE BENEFITS	-161	2,913,825	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1,701,041	3,532,411	5.00
7.00	00700 OPERATION OF PLANT	-2,379	1,185,936	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	88,759	8.00
9.00	00900 HOUSEKEEPING	0	343,600	9.00
10.00	01000 DIETARY	-4,025	120,830	10.00
11.00	01100 CAFETERIA	-60,823	381,834	11.00
13.00	01300 NURSING ADMINISTRATION	0	469,161	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-10,199	593,878	16.00
17.00	01700 SOCIAL SERVICE	0	0	17.00
17.01	01701 UTILIZATION REVIEW	0	108,236	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	0	949,696	30.00
31.00	03100 INTENSIVE CARE UNIT	0	845,064	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	1,068,985	50.00
51.00	05100 RECOVERY ROOM	0	112,581	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	-532,335	170,994	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	784,912	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	120,437	54.01
57.00	05700 CT SCAN	0	408,139	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	1,803,039	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	415,075	65.00
66.00	06600 PHYSICAL THERAPY	0	456,467	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	99,054	67.00
68.00	06800 SPEECH PATHOLOGY	0	6,266	68.00
69.00	06900 ELECTROCARDIOLOGY	0	137,323	69.00
69.01	06901 CARDIAC REHAB	-1,440	75,230	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,656	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	56,510	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-32,964	3,602,557	73.00
73.01	07301 ONCOLOGY	-80,147	265,286	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	-275	11,096	90.00
91.00	09100 EMERGENCY	-1,480,986	1,417,419	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0	0	114.00
118.00	11800 SUBTOTALS (SUM OF LINES 1-117)	-3,993,579	25,307,859	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	3,078,216	192.00
193.00	19300 NONPAID WORKERS	0	0	193.00
193.01	19301 DME	0	0	193.01
193.02	19302 LACTATION CONSULTING	0	0	193.02
193.03	19303 DIABETIC COUNSELING	0	0	193.03
194.00	07950 VACANT SPACE	0	0	194.00
194.01	07951 BOARD OF HEALTH	0	0	194.01
200.00	200.00 TOTAL (SUM OF LINES 118-199)	-3,993,579	28,386,075	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet Non-CMS W Date/Time Prepared: 5/29/2013 12:24 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
17.01	UTILIZATION REVIEW	01701		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	05401		54.01
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	CARDIAC REHAB	06901		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	ONCOLOGY	07301		73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	09910		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
114.00	UTILIZATION REVIEW-SNF	11400		114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	DME	19301		193.01
193.02	LACTATION CONSULTING	19302		193.02
193.03	DIABETIC COUNSELING	19303		193.03
194.00	VACANT SPACE	07950		194.00
194.01	BOARD OF HEALTH	07951		194.01
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	237,974	204,683	1.00	
	TOTALS		237,974	204,683		
<b>B - EMPLOYEE PROMOTIONS</b>						
1.00	EMPLOYEE BENEFITS	4.00	0	6,870	1.00	
	TOTALS		0	6,870		
<b>C - INSURANCE RECLASS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	119,635	1.00	
	TOTALS		0	119,635		
<b>D - DRUGS CHARGED</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,894,400	1.00	
	TOTALS		0	1,894,400		
<b>E - PPO DEPRECIATION</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,842	1.00	
	TOTALS		0	15,842		
<b>G - PHYSICIAN PRACTICE A&amp;G</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	425,168	0	1.00	
	TOTALS		425,168	0		
<b>H - CLINIC RECLASS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	227,297	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	512	2.00	
3.00	OPERATION OF PLANT	7.00	0	61,502	3.00	
	TOTALS		0	289,311		
<b>I - IMPLANTABLE DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	56,510	1.00	
	TOTALS		0	56,510		
500.00	Grand Total: Increases		663,142	2,587,251	500.00	

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	237,974	204,683	0		1.00
	TOTALS		237,974	204,683			
<b>B - EMPLOYEE PROMOTIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,870	0		1.00
	TOTALS		0	6,870			
<b>C - INSURANCE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	119,635	12		1.00
	TOTALS		0	119,635			
<b>D - DRUGS CHARGED</b>							
1.00	ONCOLOGY	73.01	0	1,894,400	0		1.00
	TOTALS		0	1,894,400			
<b>E - PPO DEPRECIATION</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,842	9		1.00
	TOTALS		0	15,842			
<b>G - PHYSICIAN PRACTICE A&amp;G</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	425,168	0	0		1.00
	TOTALS		425,168	0			
<b>H - CLINIC RECLASS</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	289,311	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	289,311			
<b>I - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	56,510	0		1.00
	TOTALS		0	56,510			
500.00	Grand Total: Decreases		663,142	2,587,251			500.00

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - CAFETERIA RECLASS</b>							
1.00	CAFETERIA	11.00	237,974	DIETARY	10.00	237,974	1.00
	TOTALS		237,974	TOTALS		237,974	
<b>B - EMPLOYEE PROMOTIONS</b>							
1.00	EMPLOYEE BENEFITS	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>C - INSURANCE RECLASS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>D - DRUGS CHARGED</b>							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	ONCOLOGY	73.01	0	1.00
	TOTALS		0	TOTALS		0	
<b>E - PPO DEPRECIATION</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>G - PHYSICIAN PRACTICE A&amp;G</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	425,168	PHYSICIANS' PRIVATE OFFICES	192.00	425,168	1.00
	TOTALS		425,168	TOTALS		425,168	
<b>H - CLINIC RECLASS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0		0.00	0	2.00
3.00	OPERATION OF PLANT	7.00	0		0.00	0	3.00
	TOTALS		0	TOTALS		0	
<b>I - IMPLANTABLE DEVICES</b>							
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		663,142	Grand Total: Decreases		663,142	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	159,363	0	0	0	0	1.00
2.00	Land Improvements	297,477	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,416,530	62,534	0	62,534	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,730,128	1,771,378	0	1,771,378	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,603,498	1,833,912	0	1,833,912	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,603,498	1,833,912	0	1,833,912	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	159,363	0				1.00
2.00	Land Improvements	297,477	0				2.00
3.00	Buildings and Fixtures	28,479,064	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	17,501,506	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	46,437,410	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	46,437,410	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 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	

<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,801,436	0	683,197	0	0	1.00
3.00	Total (sum of lines 1-2)	1,801,436	0	683,197	0	0	3.00

Cost Center Description	SUMMARY OF CAPITAL		
	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
	14.00	15.00	

<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,484,633	1.00
3.00	Total (sum of lines 1-2)	0	2,484,633	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/29/2013 12:24 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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,479,064	0	28,479,064	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	28,479,064	0	28,479,064	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,044,575	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,044,575	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	596,393	119,635	0	0	2,760,603	1.00
3.00	Total (sum of lines 1-2)	596,393	119,635	0	0	2,760,603	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0			0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0			0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0			0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0			0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0			0	7.00
8.00 Television and radio service (chapter 21)			0			0	8.00
9.00 Parking lot (chapter 21)			0			0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,033,729				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0			0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-60,823	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees 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	-10,199	0	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	B	-4,025	0	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00

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
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 DISCOUNTS	B	-4,893	ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 VENDOR REBATE/REFUND	B	-7,727	ADMINISTRATIVE & GENERAL	5.00		0	33.01
33.02 PHARMACY REBATES	B	-31,200	DRUGS CHARGED TO PATIENTS	73.00		0	33.02
33.03 DIABETIC COUNSELING OTHER INCOME	B	-275	CLINIC	90.00		0	33.03
33.04 OTHER MISC INCOME	B	-19,579	ADMINISTRATIVE & GENERAL	5.00		0	33.04
33.05 OTHER MISC INCOME	B	-1,764	DRUGS CHARGED TO PATIENTS	73.00		0	33.05
33.06 NONALLOWABLE INTEREST EXPENSE	A	-82,861	NEW CAP REL COSTS-BLDG & FIXT	1.00		11	33.06
33.07 INVESTMENT INCOME	B	-3,943	NEW CAP REL COSTS-BLDG & FIXT	1.00		11	33.07
33.08 LOBBYING OFFSET	A	-941	ADMINISTRATIVE & GENERAL	5.00		0	33.08
33.09 ADVERTISING OFFSET	A	-2,351	ADMINISTRATIVE & GENERAL	5.00		0	33.09
33.10 COMMUNITY RELATIONS OFFSET	A	-91,995	ADMINISTRATIVE & GENERAL	5.00		0	33.10
33.11 CRNA FEES OFFSET	A	-61,179	ANESTHESIOLOGY	53.00		0	33.11
33.12 TELEPHONE WAGES	A	-667	ADMINISTRATIVE & GENERAL	5.00		0	33.12
33.13 TELEPHONE BENEFITS	A	-161	EMPLOYEE BENEFITS	4.00		0	33.13
33.14 TELEPHONE OTHER	A	-732	ADMINISTRATIVE & GENERAL	5.00		0	33.14
33.15 PHYSICIAN RECRUITMENT	A	-11,118	ADMINISTRATIVE & GENERAL	5.00		0	33.15
33.16 CASH OVER/SHORT	B	1,661	ADMINISTRATIVE & GENERAL	5.00		0	33.16
33.17 HAF EXPENSE	A	-1,562,699	ADMINISTRATIVE & GENERAL	5.00		0	33.17
33.18 TELEVISION OFFSET	A	-2,379	OPERATION OF PLANT	7.00		0	33.18
33.19		0		0.00		0	33.19
33.20		0		0.00		0	33.20
33.21		0		0.00		0	33.21
33.22		0		0.00		0	33.22
33.23		0		0.00		0	33.23
33.24		0		0.00		0	33.24
33.25		0		0.00		0	33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,993,579				0	50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151333

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2013 12:24 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	91.00	EMERGENCY	1,705,498	1,480,986	224,512	0	0	1.00
2.00	60.00	LABORATORY	82,500	0	82,500	0	0	2.00
3.00	73.01	ONCOLOGY	80,147	80,147	0	0	0	3.00
4.00	69.01	CARDIAC REHAB	1,440	1,440	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	578,620	471,156	107,464	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			2,448,205	2,033,729	414,476	0	0	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	73.01	ONCOLOGY	0	0	0	0	0	3.00
4.00	69.01	CARDIAC REHAB	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	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	91.00	EMERGENCY	0	0	0	1,480,986		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	73.01	ONCOLOGY	0	0	0	80,147		3.00
4.00	69.01	CARDIAC REHAB	0	0	0	1,440		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	471,156		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,033,729		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2013 12:24 pm				
			Physical Therapy	Cost				
			1.00					
<b>PART I - GENERAL INFORMATION</b>								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					299	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					251	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00	
7.00	Standard travel expense rate					3.45	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	3,742.00	2,108.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	74.11	55.58	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.06	37.06	27.79			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
			1.00					
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					277,320	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					117,163	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					394,483	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					394,483	20.00	
<b>If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.</b>								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00	
23.00	Total salary equivalency (see instructions)					394,483	23.00	
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>								
<b>Standard Travel Allowance</b>								
24.00	Therapists (line 3 times column 2, line 11)					11,081	24.00	
25.00	Assistants (line 4 times column 3, line 11)					6,975	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					18,056	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,898	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					19,954	28.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					19,954	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					1,889	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>								
<b>Standard Travel Expense</b>								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2013 12:24 pm	
								Physical Therapy	Cost
								1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<b>PART V - OVERTIME COMPUTATION</b>									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		0.00	49.00
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.11	55.58	0.00	0.00				52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			0	56.00
								1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)							394,483	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							19,954	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							414,437	63.00
64.00	Total cost of outside supplier services (from your records)							409,232	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							18,056	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							1,898	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							19,954	100.02
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							1,898	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							1,898	101.02
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2013 12:24 pm	
				Occupational Therapy		Cost	
1.00							
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					225	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,914.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	54.35	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	27.18	27.18	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
1.00							
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					104,026	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					104,026	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					104,026	20.00
<b>If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.</b>							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					104,026	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					6,116	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					6,116	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					776	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,892	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					6,892	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					776	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2013 12:24 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	54.35	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					104,026	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					6,892	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					110,918	63.00
64.00	Total cost of outside supplier services (from your records)					99,054	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					6,116	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					776	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					6,892	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					776	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						101.01
101.02	Line 34 = sum of lines 27 and 31					776	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2013 12:24 pm			
			Speech Pathology	Cost			
			1.00				
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00		
2.00	Line 1 multiplied by 15 hours per week			780	2.00		
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			60	3.00		
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00		
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00		
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00		
7.00	Standard travel expense rate			3.45	7.00		
8.00	Optional travel expense rate per mile			0.00	8.00		
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	100.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.52	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.76	33.76	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
				1.00			
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00		
15.00	Therapists (column 2, line 9 times column 2, line 10)			6,752	15.00		
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00		
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			6,752	17.00		
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00		
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00		
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			6,752	20.00		
<b>If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.</b>							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			67.52	21.00		
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			52,666	22.00		
23.00	Total salary equivalency (see instructions)			52,666	23.00		
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)			2,026	24.00		
25.00	Assistants (line 4 times column 3, line 11)			0	25.00		
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			2,026	26.00		
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			207	27.00		
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			2,233	28.00		
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00		
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00		
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00		
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00		
33.00	Standard travel allowance and standard travel expense (line 28)			2,233	33.00		
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			207	34.00		
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00		
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)			0	36.00		
37.00	Assistants (line 6 times column 3, line 11)			0	37.00		
38.00	Subtotal (sum of lines 36 and 37)			0	38.00		
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00		
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00		
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00		
42.00	Subtotal (sum of lines 40 and 41)			0	42.00		
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00		
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151333				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2013 12:24 pm	
						Speech Pathology		Cost	
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<b>PART V - OVERTIME COMPUTATION</b>									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		0.00	49.00
<b>CALCULATION OF LIMIT</b>									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.52	0.00	0.00	0.00	0.00		0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		0	56.00
						1.00			
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)							52,666	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							2,233	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							54,899	63.00
64.00	Total cost of outside supplier services (from your records)							5,908	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
<b>LINE 33 CALCULATION</b>									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							2,026	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							207	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							2,233	100.02
<b>LINE 34 CALCULATION</b>									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							207	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							207	101.02
<b>LINE 35 CALCULATION</b>									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,760,603	2,760,603				1.00
4.00 00400	EMPLOYEE BENEFITS	2,913,825	0	2,913,825			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,532,411	375,869	502,026	4,410,306	4,410,306	5.00
7.00 00700	OPERATION OF PLANT	1,185,936	384,981	44,562	1,615,479	297,164	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	88,759	18,440	4,656	111,855	20,576	8.00
9.00 00900	HOUSEKEEPING	343,600	15,330	75,884	434,814	79,983	9.00
10.00 01000	DIETARY	120,830	80,553	16,630	218,013	40,103	10.00
11.00 01100	CAFETERIA	381,834	43,755	58,962	484,551	89,132	11.00
13.00 01300	NURSING ADMINISTRATION	469,161	18,140	89,725	577,026	106,143	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	593,878	114,024	56,075	763,977	140,532	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01 01701	UTILIZATION REVIEW	108,236	4,910	25,213	138,359	25,451	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	949,696	238,113	223,137	1,410,946	259,541	30.00
31.00 03100	INTENSIVE CARE UNIT	845,064	77,498	198,604	1,121,166	206,236	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,068,985	254,617	100,704	1,424,306	261,998	50.00
51.00 05100	RECOVERY ROOM	112,581	62,604	25,267	200,452	36,873	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	170,994	0	143,362	314,356	57,825	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	784,912	85,627	139,276	1,009,815	185,753	54.00
54.01 05401	NUCLEAR MEDICINE-DIAGNOSTIC	120,437	3,819	0	124,256	22,857	54.01
57.00 05700	CT SCAN	408,139	36,008	33,174	477,321	87,802	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	1,803,039	67,432	136,957	2,007,428	369,262	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	415,075	18,631	77,700	511,406	94,072	65.00
66.00 06600	PHYSICAL THERAPY	456,467	87,700	0	544,167	100,098	66.00
67.00 06700	OCCUPATIONAL THERAPY	99,054	0	0	99,054	18,221	67.00
68.00 06800	SPEECH PATHOLOGY	6,266	0	0	6,266	1,153	68.00
69.00 06900	ELECTROCARDIOLOGY	137,323	2,728	10,878	150,929	27,763	69.00
69.01 06901	CARDIAC REHAB	75,230	19,722	18,127	113,079	20,801	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,656	0	1,843	4,499	828	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	56,510	0	0	56,510	10,395	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,602,557	21,168	29,567	3,653,292	672,016	73.00
73.01 07301	ONCOLOGY	265,286	132,982	60,264	458,532	84,346	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	11,096	4,419	1,897	17,412	3,203	90.00
91.00 09100	EMERGENCY	1,417,419	163,780	233,748	1,814,947	333,856	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,307,859	2,332,850	2,308,238	24,274,519	3,653,983	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,012	0	13,012	2,394	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,078,216	349,709	605,587	4,033,512	741,966	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	DME	0	0	0	0	0	193.01
193.02 19302	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 19303	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 07950	VACANT SPACE	0	42,200	0	42,200	7,763	194.00
194.01 07951	BOARD OF HEALTH	0	22,832	0	22,832	4,200	194.01
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)	28,386,075	2,760,603	2,913,825	28,386,075	4,410,306	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,912,643				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,017	150,448			8.00
9.00	00900	HOUSEKEEPING	14,979	839	530,615		9.00
10.00	01000	DIETARY	78,705	624	23,033	360,478	10.00
11.00	01100	CAFETERIA	42,751	0	12,511	0	628,945
13.00	01300	NURSING ADMINISTRATION	17,724	0	5,187	0	23,195
16.00	01600	MEDICAL RECORDS & LIBRARY	111,408	0	32,603	0	41,525
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	4,797	0	1,404	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	232,650	32,525	68,085	331,829	87,915
31.00	03100	INTENSIVE CARE UNIT	75,720	25,127	22,159	28,649	61,306
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	248,775	23,526	72,804	0	49,292
51.00	05100	RECOVERY ROOM	61,168	0	17,901	0	6,531
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,662	11,196	24,484	0	61,145
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	3,731	0	1,092	0	0
57.00	05700	CT SCAN	35,181	0	10,296	0	13,223
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	65,885	0	19,281	0	76,384
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	18,204	0	5,327	0	26,259
66.00	06600	PHYSICAL THERAPY	85,688	4,159	25,076	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,665	0	780	0	4,488
69.01	06901	CARDIAC REHAB	19,270	0	5,639	0	6,612
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	14,325
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	20,682	0	6,053	0	13,707
73.01	07301	ONCOLOGY	129,931	4,840	38,024	0	23,033
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	4,318	0	1,264	0	484
91.00	09100	EMERGENCY	160,022	36,424	46,830	0	70,632
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,535,933	139,260	439,833	360,478	580,056
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,713	0	3,721	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341,689	11,188	80,533	0	48,889
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	DME	0	0	0	0	0
193.02	19302	LACTATION CONSULTING	0	0	0	0	0
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0
194.00	07950	VACANT SPACE	0	0	0	0	0
194.01	07951	BOARD OF HEALTH	22,308	0	6,528	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,912,643	150,448	530,615	360,478	628,945

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		NURSING ADMINISTRATIVE	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	729,275					13.00
16.00	01600	0	1,090,045				16.00
17.00	01700	0	0	0			17.00
17.01	01701	0	0	0	170,011		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	209,655	635,991	0	156,499	3,425,636	30.00
31.00	03100	146,201	0	0	13,512	1,700,076	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	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	117,551	239,204	0	0	2,437,456	50.00
51.00	05100	15,575	0	0	0	338,500	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	372,181	53.00
54.00	05400	0	5,516	0	0	1,381,571	54.00
54.01	05401	0	0	0	0	151,936	54.01
57.00	05700	0	0	0	0	623,823	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	7,144	0	0	2,545,384	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	655,268	65.00
66.00	06600	0	6,167	0	0	765,355	66.00
67.00	06700	0	0	0	0	117,275	67.00
68.00	06800	0	0	0	0	7,419	68.00
69.00	06900	0	192	0	0	186,817	69.00
69.01	06901	15,767	2,681	0	0	183,849	69.01
71.00	07100	0	0	0	0	19,652	71.00
72.00	07200	0	0	0	0	66,905	72.00
73.00	07300	0	0	0	0	4,365,750	73.00
73.01	07301	54,930	4,922	0	0	798,558	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,154	0	0	0	27,835	90.00
91.00	09100	168,442	187,213	0	0	2,818,366	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
114.00	11400						114.00
118.00		729,275	1,089,030	0	170,011	22,989,612	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	31,840	190.00
192.00	19200	0	1,015	0	0	5,258,792	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	0	0	0	0	49,963	194.00
194.01	07951	0	0	0	0	55,868	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		729,275	1,090,045	0	170,011	28,386,075	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	UTILIZATION REVIEW		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0 3,425,636	30.00
31.00	03100	INTENSIVE CARE UNIT	0 1,700,076	31.00
41.00	04100	SUBPROVIDER - IRF	0 0	41.00
42.00	04200	SUBPROVIDER	0 0	42.00
43.00	04300	NURSERY	0 0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0 2,437,456	50.00
51.00	05100	RECOVERY ROOM	0 338,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0 0	52.00
53.00	05300	ANESTHESIOLOGY	0 372,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 1,381,571	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0 151,936	54.01
57.00	05700	CT SCAN	0 623,823	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 2,545,384	60.00
60.01	06001	BLOOD LABORATORY	0 0	60.01
64.00	06400	INTRAVENOUS THERAPY	0 0	64.00
65.00	06500	RESPIRATORY THERAPY	0 655,268	65.00
66.00	06600	PHYSICAL THERAPY	0 765,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 117,275	67.00
68.00	06800	SPEECH PATHOLOGY	0 7,419	68.00
69.00	06900	ELECTROCARDIOLOGY	0 186,817	69.00
69.01	06901	CARDIAC REHAB	0 183,849	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 19,652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0 66,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 4,365,750	73.00
73.01	07301	ONCOLOGY	0 798,558	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0 0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0 0	89.00
90.00	09000	CLINIC	0 27,835	90.00
91.00	09100	EMERGENCY	0 2,818,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0 0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0 0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	PANCREAS ACQUISITION	0 0	109.00
110.00	11000	INTESTINAL ACQUISITION	0 0	110.00
111.00	11100	ISLET ACQUISITION	0 0	111.00
113.00	11300	INTEREST EXPENSE	0 0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0 0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0 22,989,612	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 31,840	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 5,258,792	192.00
193.00	19300	NONPAID WORKERS	0 0	193.00
193.01	19301	DME	0 0	193.01
193.02	19302	LACTATION CONSULTING	0 0	193.02
193.03	19303	DIABETIC COUNSELING	0 0	193.03
194.00	07950	VACANT SPACE	0 49,963	194.00
194.01	07951	BOARD OF HEALTH	0 55,868	194.01
200.00		Cross Foot Adjustments	0 0	200.00
201.00		Negative Cost Centers	0 0	201.00
202.00		TOTAL (sum lines 118-201)	0 28,386,075	202.00

COST ALLOCATION STATISTICS

Provider CCN: 151333

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

Worksheet Non-CMS W  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	3		1.00
4.00	EMPLOYEE BENEFITS	5		4.00
5.00	ADMINISTRATIVE & GENERAL	-6		5.00
7.00	OPERATION OF PLANT	5		7.00
8.00	LAUNDRY & LINEN SERVICE	9		8.00
9.00	HOUSEKEEPING	33		9.00
10.00	DIETARY	11		10.00
11.00	CAFETERIA	12		11.00
13.00	NURSING ADMINISTRATION	14		13.00
16.00	MEDICAL RECORDS & LIBRARY	17		16.00
17.00	SOCIAL SERVICE	18		17.00
17.01	UTILIZATION REVIEW	11		17.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
		0	1.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	375,869	375,869	0	5.00
7.00	00700	OPERATION OF PLANT	0	384,981	384,981	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,440	18,440	0	8.00
9.00	00900	HOUSEKEEPING	0	15,330	15,330	0	9.00
10.00	01000	DIETARY	0	80,553	80,553	0	10.00
11.00	01100	CAFETERIA	0	43,755	43,755	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	18,140	18,140	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	114,024	114,024	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	4,910	4,910	0	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	238,113	238,113	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	77,498	77,498	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	254,617	254,617	0	50.00
51.00	05100	RECOVERY ROOM	0	62,604	62,604	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,627	85,627	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,819	3,819	0	54.01
57.00	05700	CT SCAN	0	36,008	36,008	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	67,432	67,432	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	18,631	18,631	0	65.00
66.00	06600	PHYSICAL THERAPY	0	87,700	87,700	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,728	2,728	0	69.00
69.01	06901	CARDIAC REHAB	0	19,722	19,722	0	69.01
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	21,168	21,168	0	73.00
73.01	07301	ONCOLOGY	0	132,982	132,982	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	4,419	4,419	0	90.00
91.00	09100	EMERGENCY	0	163,780	163,780	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,332,850	2,332,850	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,012	13,012	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	349,709	349,709	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	DME	0	0	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	0	0	193.03
194.00	07950	VACANT SPACE	0	42,200	42,200	0	194.00
194.01	07951	BOARD OF HEALTH	0	22,832	22,832	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,760,603	2,760,603	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	410,307				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,865	24,059			8.00
9.00	00900	HOUSEKEEPING	3,213	134	25,494		9.00
10.00	01000	DIETARY	16,884	100	1,107	102,062	10.00
11.00	01100	CAFETERIA	9,171	0	601	0	61,123
13.00	01300	NURSING ADMINISTRATION	3,802	0	249	0	2,254
16.00	01600	MEDICAL RECORDS & LIBRARY	23,900	0	1,566	0	4,036
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	1,029	0	67	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	49,909	5,201	3,271	93,950	8,545
31.00	03100	INTENSIVE CARE UNIT	16,244	4,018	1,065	8,112	5,958
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	53,368	3,762	3,498	0	4,790
51.00	05100	RECOVERY ROOM	13,122	0	860	0	635
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,948	1,790	1,176	0	5,942
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	800	0	52	0	0
57.00	05700	CT SCAN	7,547	0	495	0	1,285
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	14,134	0	926	0	7,423
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,905	0	256	0	2,552
66.00	06600	PHYSICAL THERAPY	18,382	665	1,205	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	572	0	37	0	436
69.01	06901	CARDIAC REHAB	4,134	0	271	0	643
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,392
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,437	0	291	0	1,332
73.01	07301	ONCOLOGY	27,873	774	1,827	0	2,238
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	926	0	61	0	47
91.00	09100	EMERGENCY	34,329	5,826	2,250	0	6,864
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
118.00		SUBTOTALS (SUM OF LINES 1-117)	329,494	22,270	21,131	102,062	56,372
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,727	0	179	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,300	1,789	3,870	0	4,751
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	DME	0	0	0	0	0
193.02	19302	LACTATION CONSULTING	0	0	0	0	0
193.03	19303	DIABETIC COUNSELING	0	0	0	0	0
194.00	07950	VACANT SPACE	0	0	0	0	0
194.01	07951	BOARD OF HEALTH	4,786	0	314	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	410,307	24,059	25,494	102,062	61,123

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/29/2013 12:24 pm
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Cost Center Description		NURSING ADMINISTRATIVE	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	33,491					13.00
16.00	01600	0	155,503				16.00
17.00	01700	0	0	0			17.00
17.01	01701	0	0	0	8,175		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	9,629	90,729	0	7,525	528,991	30.00
31.00	03100	6,714	0	0	650	137,836	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	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	5,398	34,124	0	0	381,886	50.00
51.00	05100	715	0	0	0	81,078	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	4,928	53.00
54.00	05400	0	787	0	0	129,101	54.00
54.01	05401	0	0	0	0	6,619	54.01
57.00	05700	0	0	0	0	52,818	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,019	0	0	122,404	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	33,361	65.00
66.00	06600	0	880	0	0	117,363	66.00
67.00	06700	0	0	0	0	1,553	67.00
68.00	06800	0	0	0	0	98	68.00
69.00	06900	0	27	0	0	6,166	69.00
69.01	06901	724	383	0	0	27,650	69.01
71.00	07100	0	0	0	0	1,463	71.00
72.00	07200	0	0	0	0	886	72.00
73.00	07300	0	0	0	0	84,501	73.00
73.01	07301	2,523	702	0	0	176,107	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	53	0	0	0	5,779	90.00
91.00	09100	7,735	26,707	0	0	275,944	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
114.00	11400						114.00
118.00		33,491	155,358	0	8,175	2,176,532	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	16,122	190.00
192.00	19200	0	145	0	0	496,797	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
194.00	07950	0	0	0	0	42,862	194.00
194.01	07951	0	0	0	0	28,290	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		33,491	155,503	0	8,175	2,760,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01701	UTILIZATION REVIEW		17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	528,991
31.00	03100	INTENSIVE CARE UNIT	0	137,836
41.00	04100	SUBPROVIDER - IRF	0	0
42.00	04200	SUBPROVIDER	0	0
43.00	04300	NURSERY	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	381,886
51.00	05100	RECOVERY ROOM	0	81,078
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	4,928
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,101
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	6,619
57.00	05700	CT SCAN	0	52,818
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	122,404
60.01	06001	BLOOD LABORATORY	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0
65.00	06500	RESPIRATORY THERAPY	0	33,361
66.00	06600	PHYSICAL THERAPY	0	117,363
67.00	06700	OCCUPATIONAL THERAPY	0	1,553
68.00	06800	SPEECH PATHOLOGY	0	98
69.00	06900	ELECTROCARDIOLOGY	0	6,166
69.01	06901	CARDIAC REHAB	0	27,650
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,463
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	886
73.00	07300	DRUGS CHARGED TO PATIENTS	0	84,501
73.01	07301	ONCOLOGY	0	176,107
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	5,779
91.00	09100	EMERGENCY	0	275,944
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	PANCREAS ACQUISITION	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0
111.00	11100	ISLET ACQUISITION	0	0
113.00	11300	INTEREST EXPENSE		
114.00	11400	UTILIZATION REVIEW-SNF		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,176,532
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,122
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	496,797
193.00	19300	NONPAID WORKERS	0	0
193.01	19301	DME	0	0
193.02	19302	LACTATION CONSULTING	0	0
193.03	19303	DIABETIC COUNSELING	0	0
194.00	07950	VACANT SPACE	0	42,862
194.01	07951	BOARD OF HEALTH	0	28,290
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	2,760,603

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	CAPI TAL	EMPLOYEE	Reconci liatio n	ADMI NI STRATI V	OPERATION OF	
	RELATED COSTS					
	NEW BLDG & FIXT (SQUARE FEET)	(GROSS SALARIES)	5A	(ACCU M. COST)	(SQUARE FEET)	
	1.00	4.00		5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	101,201					1.00
4.00 00400 EMPLOYEE BENEFITS	0	11,760,436				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	13,779	2,026,217	-4,410,306	23,975,769		5.00
7.00 00700 OPERATION OF PLANT	14,113	179,855	0	1,615,479	71,762	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	676	18,792	0	111,855	676	8.00
9.00 00900 HOUSEKEEPING	562	306,275	0	434,814	562	9.00
10.00 01000 DIETARY	2,953	67,122	0	218,013	2,953	10.00
11.00 01100 CAFETERIA	1,604	237,974	0	484,551	1,604	11.00
13.00 01300 NURSING ADMINISTRATION	665	362,139	0	577,026	665	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	4,180	226,322	0	763,977	4,180	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
17.01 01701 UTILIZATION REVIEW	180	101,762	0	138,359	180	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	8,729	900,600	0	1,410,946	8,729	30.00
31.00 03100 INTENSIVE CARE UNIT	2,841	801,584	0	1,121,166	2,841	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	9,334	406,448	0	1,424,306	9,334	50.00
51.00 05100 RECOVERY ROOM	2,295	101,980	0	200,452	2,295	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	578,619	0	314,356	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,139	562,131	0	1,009,815	3,139	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	140	0	0	124,256	140	54.01
57.00 05700 CT SCAN	1,320	133,892	0	477,321	1,320	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	2,472	552,769	0	2,007,428	2,472	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	683	313,602	0	511,406	683	65.00
66.00 06600 PHYSICAL THERAPY	3,215	0	0	544,167	3,215	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	99,054	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	6,266	0	68.00
69.00 06900 ELECTROCARDIOLOGY	100	43,904	0	150,929	100	69.00
69.01 06901 CARDIAC REHAB	723	73,164	0	113,079	723	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,440	0	4,499	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	56,510	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	776	119,336	0	3,653,292	776	73.00
73.01 07301 ONCOLOGY	4,875	243,229	0	458,532	4,875	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	162	7,657	0	17,412	162	90.00
91.00 09100 EMERGENCY	6,004	943,427	0	1,814,947	6,004	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00	85,520	9,316,240	-4,410,306	19,864,213	57,628	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	0	13,012	477	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	12,820	2,444,196	0	4,033,512	12,820	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 DME	0	0	0	0	0	193.01
193.02 19302 LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 19303 DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 07950 VACANT SPACE	1,547	0	0	42,200	0	194.00
194.01 07951 BOARD OF HEALTH	837	0	0	22,832	837	194.01
200.00						200.00
201.00						201.00
202.00	2,760,603	2,913,825		4,410,306	1,912,643	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)				
		1.00	4.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	27.278416	0.247765	5A	0.183948	26.652588	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		0		375,869	410,307	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.015677	5.717608	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
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	37,116					8.00
9.00	00900 HOUSEKEEPING	207	68,029				9.00
10.00	01000 DIETARY	154	2,953	3,284			10.00
11.00	01100 CAFETERIA	0	1,604	0	23,401		11.00
13.00	01300 NURSING ADMINISTRATION	0	665	0	863	11,378	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4,180	0	1,545	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701 UTILIZATION REVIEW	0	180	0	0	0	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	8,024	8,729	3,023	3,271	3,271	30.00
31.00	03100 INTENSIVE CARE UNIT	6,199	2,841	261	2,281	2,281	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	5,804	9,334	0	1,834	1,834	50.00
51.00	05100 RECOVERY ROOM	0	2,295	0	243	243	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,762	3,139	0	2,275	0	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	140	0	0	0	54.01
57.00	05700 CT SCAN	0	1,320	0	492	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	2,472	0	2,842	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	683	0	977	0	65.00
66.00	06600 PHYSICAL THERAPY	1,026	3,215	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	100	0	167	0	69.00
69.01	06901 CARDIAC REHAB	0	723	0	246	246	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	533	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	776	0	510	0	73.00
73.01	07301 ONCOLOGY	1,194	4,875	0	857	857	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	162	0	18	18	90.00
91.00	09100 EMERGENCY	8,986	6,004	0	2,628	2,628	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	34,356	56,390	3,284	21,582	11,378	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	477	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,760	10,325	0	1,819	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 DME	0	0	0	0	0	193.01
193.02	19302 LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	19303 DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	07950 VACANT SPACE	0	0	0	0	0	194.00
194.01	07951 BOARD OF HEALTH	0	837	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	150,448	530,615	360,478	628,945	729,275	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.053454	7.799835	109.767966	26.876843	64.095184	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	24,059	25,494	102,062	61,123	33,491	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.648211	0.374752	31.078563	2.611982	2.943487	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		16.00	17.00	17.01	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,824		16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	3,284	17.01
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	66,411	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	24,978	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.01
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	746	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	644	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20	0	69.00
69.01	06901	CARDIAC REHAB	280	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	ONCOLOGY	514	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	19,549	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,718	0	3,284
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	DME	0	0	193.01
193.02	19302	LACTATION CONSULTING	0	0	193.02
193.03	19303	DIABETIC COUNSELING	0	0	193.03
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,090,045	0	170,011
203.00		Unit cost multiplier (Wkst. B, Part I)	9.576583	0.000000	51.769488

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		16.00	17.00	17.01	
204.00	Cost to be allocated (per Wkst. B, Part II)	155,503	0	8,175	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.366171	0.000000	2.489342	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

		Title XVIII			Hospital		Cost		
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	3,425,636		3,425,636	0	0	1,645,966	30.00
31.00	03100	INTENSIVE CARE UNIT	1,700,076		1,700,076	0	0	1,021,683	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
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	2,437,456		2,437,456	0	0	753,339	50.00
51.00	05100	RECOVERY ROOM	338,500		338,500	0	0	62,338	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	372,181		372,181	0	0	20,651	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,381,571		1,381,571	0	0	454,906	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	151,936		151,936	0	0	29,877	54.01
57.00	05700	CT SCAN	623,823		623,823	0	0	931,286	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	2,545,384		2,545,384	0	0	1,365,997	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	655,268	0	655,268	0	0	875,988	65.00
66.00	06600	PHYSICAL THERAPY	765,355	0	765,355	0	0	428,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,275	0	117,275	0	0	174,007	67.00
68.00	06800	SPEECH PATHOLOGY	7,419	0	7,419	0	0	9,812	68.00
69.00	06900	ELECTROCARDIOLOGY	186,817		186,817	0	0	38,501	69.00
69.01	06901	CARDIAC REHAB	183,849		183,849	0	0	1,325	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,652		19,652	0	0	87,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	66,905		66,905	0	0	39,039	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,365,750		4,365,750	0	0	1,779,552	73.00
73.01	07301	ONCOLOGY	798,558		798,558	0	0	496	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	27,835		27,835	0	0	0	90.00
91.00	09100	EMERGENCY	2,818,366		2,818,366	0	0	121,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	754,128		754,128	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
99.10	09910	CORF	0		0			0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>									
109.00	10900	PANCREAS ACQUISITION	0		0			0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0			0	110.00
111.00	11100	ISLET ACQUISITION	0		0			0	111.00
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	23,743,740	0	23,743,740	0	0	9,842,827	200.00
201.00		Less Observation Beds	754,128		754,128				201.00
202.00		Total (see instructions)	22,989,612	0	22,989,612	0	0	9,842,827	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital Cost	
		Outpatient	Total (col. 6 + col. 7)					
		7.00	8.00					
		9.00	10.00	11.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS		1,645,966				30.00
31.00	03100	INTENSIVE CARE UNIT		1,021,683				31.00
41.00	04100	SUBPROVIDER - IRF		0				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		0				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,494,726	4,248,065	0.573780	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	400,294	462,632	0.731683	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	134,626	155,277	2.396884	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,060,087	4,514,993	0.305996	0.000000	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	415,502	445,379	0.341139	0.000000	0.000000	54.01
57.00	05700	CT SCAN	9,037,663	9,968,949	0.062577	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000	59.00
60.00	06000	LABORATORY	8,512,256	9,878,253	0.257676	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	396,375	1,272,363	0.515001	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,320,133	1,748,977	0.437602	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,232	415,239	0.282428	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,420	30,232	0.245402	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	903,886	942,387	0.198238	0.000000	0.000000	69.00
69.01	06901	CARDIAC REHAB	204,450	205,775	0.893447	0.000000	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,615	228,611	0.085963	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	144,205	183,244	0.365114	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,988,817	7,768,369	0.561991	0.000000	0.000000	73.00
73.01	07301	ONCOLOGY	586,593	587,089	1.360199	0.000000	0.000000	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000	CLINIC	3,557	3,557	7.825415	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	5,220,088	5,341,312	0.527654	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,726	950,726	0.793213	0.000000	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0				99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0				111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	42,176,251	52,019,078				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,176,251	52,019,078				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	3,425,636		3,425,636	0	0	1,645,966	30.00
31.00	03100	INTENSIVE CARE UNIT	1,700,076		1,700,076	0	0	1,021,683	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
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	2,437,456		2,437,456	0	0	753,339	50.00
51.00	05100	RECOVERY ROOM	338,500		338,500	0	0	62,338	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	372,181		372,181	0	0	20,651	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,381,571		1,381,571	0	0	454,906	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	151,936		151,936	0	0	29,877	54.01
57.00	05700	CT SCAN	623,823		623,823	0	0	931,286	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	2,545,384		2,545,384	0	0	1,365,997	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	655,268	0	655,268	0	0	875,988	65.00
66.00	06600	PHYSICAL THERAPY	765,355	0	765,355	0	0	428,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,275	0	117,275	0	0	174,007	67.00
68.00	06800	SPEECH PATHOLOGY	7,419	0	7,419	0	0	9,812	68.00
69.00	06900	ELECTROCARDIOLOGY	186,817		186,817	0	0	38,501	69.00
69.01	06901	CARDIAC REHAB	183,849		183,849	0	0	1,325	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,652		19,652	0	0	87,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	66,905		66,905	0	0	39,039	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,365,750		4,365,750	0	0	1,779,552	73.00
73.01	07301	ONCOLOGY	798,558		798,558	0	0	496	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	27,835		27,835	0	0	0	90.00
91.00	09100	EMERGENCY	2,818,366		2,818,366	0	0	121,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	754,128		754,128	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
99.10	09910	CORF	0		0		0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>									
109.00	10900	PANCREAS ACQUISITION	0		0		0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	0	111.00
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	23,743,740	0	23,743,740	0	0	9,842,827	200.00
201.00		Less Observation Beds	754,128		754,128		0		201.00
202.00		Total (see instructions)	22,989,612	0	22,989,612	0	0	9,842,827	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital Cost	
		Outpatient	Total (col. 6 + col. 7)					
		7.00	8.00					
		9.00	10.00	11.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS		1,645,966				30.00
31.00	03100	INTENSIVE CARE UNIT		1,021,683				31.00
41.00	04100	SUBPROVIDER - IRF		0				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		0				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,494,726	4,248,065	0.573780	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	400,294	462,632	0.731683	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	134,626	155,277	2.396884	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,060,087	4,514,993	0.305996	0.000000	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	415,502	445,379	0.341139	0.000000	0.000000	54.01
57.00	05700	CT SCAN	9,037,663	9,968,949	0.062577	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000	59.00
60.00	06000	LABORATORY	8,512,256	9,878,253	0.257676	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	396,375	1,272,363	0.515001	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,320,133	1,748,977	0.437602	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	241,232	415,239	0.282428	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,420	30,232	0.245402	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	903,886	942,387	0.198238	0.000000	0.000000	69.00
69.01	06901	CARDIAC REHAB	204,450	205,775	0.893447	0.000000	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,615	228,611	0.085963	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	144,205	183,244	0.365114	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,988,817	7,768,369	0.561991	0.000000	0.000000	73.00
73.01	07301	ONCOLOGY	586,593	587,089	1.360199	0.000000	0.000000	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
90.00	09000	CLINIC	3,557	3,557	7.825415	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	5,220,088	5,341,312	0.527654	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	950,726	950,726	0.793213	0.000000	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0				99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0				111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	42,176,251	52,019,078				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,176,251	52,019,078				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/29/2013 12:24 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	381,886	4,248,065	0.089896	260,522	23,420	50.00
51.00	05100 RECOVERY ROOM	81,078	462,632	0.175254	27,192	4,766	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	4,928	155,277	0.031737	13,605	432	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	129,101	4,514,993	0.028594	197,711	5,653	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	6,619	445,379	0.014861	21,639	322	54.01
57.00	05700 CT SCAN	52,818	9,968,949	0.005298	239,059	1,267	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	122,404	9,878,253	0.012391	764,032	9,467	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	33,361	1,272,363	0.026220	648,526	17,004	65.00
66.00	06600 PHYSICAL THERAPY	117,363	1,748,977	0.067104	139,858	9,385	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,553	415,239	0.003740	43,457	163	67.00
68.00	06800 SPEECH PATHOLOGY	98	30,232	0.003242	8,426	27	68.00
69.00	06900 ELECTROCARDIOLOGY	6,166	942,387	0.006543	22,240	146	69.00
69.01	06901 CARDIAC REHAB	27,650	205,775	0.134370	1,325	178	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,463	228,611	0.006400	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	886	183,244	0.004835	39,039	189	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	84,501	7,768,369	0.010878	1,034,038	11,248	73.00
73.01	07301 ONCOLOGY	176,107	587,089	0.299966	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	5,779	3,557	1.624684	0	0	90.00
91.00	09100 EMERGENCY	275,944	5,341,312	0.051662	11,805	610	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	950,726	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	1,509,705	49,351,429		3,472,474	84,277	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col . 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	4,248,065	0.000000	0.000000	260,522	50.00
51.00	05100 RECOVERY ROOM	0	462,632	0.000000	0.000000	27,192	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	155,277	0.000000	0.000000	13,605	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,514,993	0.000000	0.000000	197,711	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	445,379	0.000000	0.000000	21,639	54.01
57.00	05700 CT SCAN	0	9,968,949	0.000000	0.000000	239,059	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	9,878,253	0.000000	0.000000	764,032	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,272,363	0.000000	0.000000	648,526	65.00
66.00	06600 PHYSICAL THERAPY	0	1,748,977	0.000000	0.000000	139,858	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	415,239	0.000000	0.000000	43,457	67.00
68.00	06800 SPEECH PATHOLOGY	0	30,232	0.000000	0.000000	8,426	68.00
69.00	06900 ELECTROCARDIOLOGY	0	942,387	0.000000	0.000000	22,240	69.00
69.01	06901 CARDIAC REHAB	0	205,775	0.000000	0.000000	1,325	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	228,611	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	183,244	0.000000	0.000000	39,039	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,768,369	0.000000	0.000000	1,034,038	73.00
73.01	07301 ONCOLOGY	0	587,089	0.000000	0.000000	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	3,557	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	5,341,312	0.000000	0.000000	11,805	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	950,726	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	49,351,429			3,472,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Title XVIII			Hospital		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School			
		11.00	12.00	13.00	21.00	22.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000 OPERATING ROOM	0	0	0	0	0	0	50.00	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	54.01	
57.00	05700 CT SCAN	0	0	0	0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00	
60.00	06000 LABORATORY	0	0	0	0	0	0	60.00	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01	
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
69.01	06901 CARDIAC REHAB	0	0	0	0	0	0	69.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
73.01	07301 ONCOLOGY	0	0	0	0	0	0	73.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00	
90.00	09000 CLINIC	0	0	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00	
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0			54.01
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
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
69.01	06901 CARDIAC REHAB	0	0			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
73.01	07301 ONCOLOGY	0	0			73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.573780	0	1,013,068	0	0	50.00
51.00	05100	RECOVERY ROOM	0.731683	0	111,163	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2.396884	0	70,382	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305996	0	1,019,960	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.341139	0	125,326	0	0	54.01
57.00	05700	CT SCAN	0.062577	0	2,614,119	30	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.257676	0	2,966,201	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.515001	0	289,911	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.437602	0	372,349	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.282428	0	66,080	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.245402	0	4,984	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.198238	0	309,447	0	0	69.00
69.01	06901	CARDIAC REHAB	0.893447	0	75,591	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.085963	0	138	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.365114	0	47,964	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.561991	0	2,639,847	788	0	73.00
73.01	07301	ONCOLOGY	1.360199	0	241,064	143	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	7.825415	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.527654	0	1,219,512	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.793213	0	430,605	0	0	92.00
200.00		Subtotal (see instructions)		0	13,617,711	961	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,617,711	961	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	581,278	0		50.00
51.00 05100 RECOVERY ROOM	81,336	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	168,697	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	312,104	0		54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	42,754	0		54.01
57.00 05700 CT SCAN	163,584	2		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	764,319	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	149,304	0		65.00
66.00 06600 PHYSICAL THERAPY	162,941	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	18,663	0		67.00
68.00 06800 SPEECH PATHOLOGY	1,223	0		68.00
69.00 06900 ELECTROCARDIOLOGY	61,344	0		69.00
69.01 06901 CARDIAC REHAB	67,537	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	17,512	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,483,570	443		73.00
73.01 07301 ONCOLOGY	327,895	195		73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	643,480	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	341,561	0		92.00
200.00 Subtotal (see instructions)	5,389,114	640		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,389,114	640		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
		Component CCN: 15Z333	Title XVIII	Swing Beds - SNF
		Charges		Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.573780	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.731683	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	2.396884	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.305996	0	0	0	0 54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.341139	0	0	0	0 54.01
57.00	05700 CT SCAN	0.062577	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.257676	0	0	0	0 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.515001	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.437602	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.282428	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.245402	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.198238	0	0	0	0 69.00
69.01	06901 CARDIAC REHAB	0.893447	0	0	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.085963	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365114	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.561991	0	0	0	0 73.00
73.01	07301 ONCOLOGY	1.360199	0	0	0	0 73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00	09000 CLINIC	7.825415	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.527654	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.793213	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151333	Period: From 01/01/2012	Worksheet D
		Component CCN: 15Z333	To 12/31/2012	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 5/29/2013 12:24 pm
				Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
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
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01 07301 ONCOLOGY	0	0		73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
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)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2013 12:24 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,391	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,682	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)		1,962	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		569	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		140	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,294	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)		569	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		146.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		146.75	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,425,636	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)		20,545	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)		616,516	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,809,120	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,059,717	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,059,717	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.363838	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)		1,049.80	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)		2,809,120	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,047.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,355,336	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,355,336	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description			Title XVIII		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00	INTENSIVE CARE UNIT	1,700,076	572	2,972.16	383	1,138,337 43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
<b>Cost Center Description</b>						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,498,433	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,992,106	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				595,971	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)				595,971	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00	Total observation bed days (see instructions)				720	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,047.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				754,128	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2013 12:24 pm
Cost Center Description		Cost		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,391	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,682	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)		1,962	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		569	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		140	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)		74	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,425,636	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)		599,567	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,826,069	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,059,717	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,059,717	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.372067	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)		1,049.80	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)		2,826,069	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,053.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		77,975	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)		77,975	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151333		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
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)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	1,700,076	572	2,972.16	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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					85,656		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					163,631		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)							0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							0 53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges							0 54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)							0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0 57.00
58.00 Bonus payment (see instructions)							0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0 61.00
62.00 Relief payment (see instructions)							0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							0 63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0 69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					720		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,053.72		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					758,678		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151333

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

Worksheet D-1

Date/Time Prepared:  
5/29/2013 12:24 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,022,918		30.00
31.00	03100 INTENSIVE CARE UNIT		602,184		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.573780	260,522	149,482	50.00
51.00	05100 RECOVERY ROOM	0.731683	27,192	19,896	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2.396884	13,605	32,610	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.305996	197,711	60,499	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.341139	21,639	7,382	54.01
57.00	05700 CT SCAN	0.062577	239,059	14,960	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.257676	764,032	196,873	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.515001	648,526	333,992	65.00
66.00	06600 PHYSICAL THERAPY	0.437602	139,858	61,202	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.282428	43,457	12,273	67.00
68.00	06800 SPEECH PATHOLOGY	0.245402	8,426	2,068	68.00
69.00	06900 ELECTROCARDIOLOGY	0.198238	22,240	4,409	69.00
69.01	06901 CARDIAC REHAB	0.893447	1,325	1,184	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.085963	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365114	39,039	14,254	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.561991	1,034,038	581,120	73.00
73.01	07301 ONCOLOGY	1.360199	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	7.825415	0	0	90.00
91.00	09100 EMERGENCY	0.527654	11,805	6,229	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.793213	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,472,474	1,498,433	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)		3,472,474		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15Z333		Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		266,244	30.00
31.00	03100	INTENSIVE CARE UNIT		514	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.573780	793	455 50.00
51.00	05100	RECOVERY ROOM	0.731683	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	2.396884	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305996	10,570	3,234 54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.341139	0	0 54.01
57.00	05700	CT SCAN	0.062577	5,197	325 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.257676	79,794	20,561 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.515001	102,149	52,607 65.00
66.00	06600	PHYSICAL THERAPY	0.437602	188,075	82,302 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.282428	107,648	30,403 67.00
68.00	06800	SPEECH PATHOLOGY	0.245402	273	67 68.00
69.00	06900	ELECTROCARDIOLOGY	0.198238	922	183 69.00
69.01	06901	CARDIAC REHAB	0.893447	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.085963	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.365114	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.561991	182,287	102,444 73.00
73.01	07301	ONCOLOGY	1.360199	0	0 73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	7.825415	0	0 90.00
91.00	09100	EMERGENCY	0.527654	560	295 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.793213	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		678,268	292,876 200.00
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)		678,268	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		26,828		30.00
31.00	03100 INTENSIVE CARE UNIT		35,448		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.573780	15,743	9,033	50.00
51.00	05100 RECOVERY ROOM	0.731683	3,579	2,619	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2.396884	1,232	2,953	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.305996	8,812	2,696	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.341139	4,434	1,513	54.01
57.00	05700 CT SCAN	0.062577	39,959	2,501	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.257676	53,577	13,806	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.515001	6,150	3,167	65.00
66.00	06600 PHYSICAL THERAPY	0.437602	3,313	1,450	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.282428	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.245402	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.198238	8,715	1,728	69.00
69.01	06901 CARDIAC REHAB	0.893447	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.085963	45,792	3,936	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.365114	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.561991	55,733	31,321	73.00
73.01	07301 ONCOLOGY	1.360199	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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
90.00	09000 CLINIC	7.825415	0	0	90.00
91.00	09100 EMERGENCY	0.527654	16,930	8,933	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.793213	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		263,969	85,656	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)		263,969		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			5,389,754 1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,389,754 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,443,652 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			43,894 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,125,458 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)			3,274,300 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)			3,274,300 30.00
31.00	Primary payer payments			2,837 31.00
32.00	Subtotal (line 30 minus line 31)			3,271,463 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			129,471 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			129,471 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			97,344 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,400,934 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,400,934 40.00
41.00	Interim payments			3,365,041 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)			35,893 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151333

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,101,121		3,145,405	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
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	01/01/2012	44,656	01/01/2012	219,636		3.01
3.02		08/23/2012	38,800		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		83,456		219,636		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,184,577		3,365,041		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		494,148		35,893		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		3,678,725		3,400,934		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151333  
Component CCN: 15Z333

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		736,288		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		736,288		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		143,385		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		879,673		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			720 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,677 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			359 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,534 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			52,019,078 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			902,587 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			1,508,627 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,508,627 8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,286,823 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			221,804 32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151333

Period:

Worksheet E-2

Component CCN: 15Z333

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

Date/Time Prepared:  
5/29/2013 12:24 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		601,931	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		295,805	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		569	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		897,736	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		897,736	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		897,736	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		18,063	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		879,673	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
17.00	Reimbursable bad debts (see instructions)		0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		879,673	0	19.00
20.00	Interim payments		736,288	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		143,385	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services			3,992,106 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			3,992,106 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,032,027 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			4,032,027 19.00
20.00	Deductibles (exclude professional component)			330,314 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,701,713 22.00
23.00	Coinsurance			7,225 23.00
24.00	Subtotal (line 22 minus line 23)			3,694,488 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			-15,763 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			-15,763 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-19,024 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,678,725 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			3,678,725 30.00
31.00	Interim payments			3,184,577 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			494,148 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		163,631		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)		163,631	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)		163,631	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		62,276		8.00
9.00	Ancillary service charges		263,969	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)		326,245	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		326,245	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		162,614	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)		163,631	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		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)		163,631	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		163,631	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		163,631	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		163,631	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)		163,631	0	40.00
41.00	Interim payments		256,689	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-93,058	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: 151333

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

Worksheet G

Date/Time Prepared:  
5/29/2013 12:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,062,506	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,950,920	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,845,039	0	0	0	6.00
7.00	Inventory	970,231	0	0	0	7.00
8.00	Prepaid expenses	201,266	0	0	0	8.00
9.00	Other current assets	811,085	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,150,969	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	159,363	0	0	0	12.00
13.00	Land improvements	297,479	0	0	0	13.00
14.00	Accumulated depreciation	-232,339	0	0	0	14.00
15.00	Buildings	28,681,982	0	0	0	15.00
16.00	Accumulated depreciation	-16,490,544	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,501,507	0	0	0	23.00
24.00	Accumulated depreciation	-12,887,243	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)	17,030,205	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	252,062	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,459,806	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,711,868	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,893,042	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	691,482	0	0	0	37.00
38.00	Salaries, wages, and fees payable	297,717	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	742,931	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	1,808,899	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,541,029	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,449,325	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,007,719	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,457,044	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,998,073	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	12,894,969				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)	12,894,969	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,893,042	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151333

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

Worksheet G-1

Date/Time Prepared:  
5/29/2013 12:24 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		12,562,147			0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		332,822				2.00
3.00	Total (sum of line 1 and line 2)		12,894,969			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		12,894,969			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,894,969			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			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: 151333

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	2,059,717		2,059,717	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)	2,059,717		2,059,717	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	1,558,658		1,558,658	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,558,658		1,558,658	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,618,375		3,618,375	17.00
18.00	Ancillary services	7,180,726	37,378,900	44,559,626	18.00
19.00	Outpatient services	194,319	8,550,403	8,744,722	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICE	473,421	4,923,312	5,396,733	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,466,841	50,852,615	62,319,456	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,379,654		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,379,654		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151333

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

Worksheet G-3

Date/Time Prepared:  
5/29/2013 12:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,319,456	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,755,555	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,563,901	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,379,654	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,815,753	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	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 (SPECIFY)	2,148,575	24.00
25.00	Total other income (sum of lines 6-24)	2,148,575	25.00
26.00	Total (line 5 plus line 25)	332,822	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	332,822	29.00