

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: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet S Parts I-III Date/Time Prepared: 9/27/2012 2:55 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: 9/27/2012 Time: 2:55 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 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 COMMUNITY HOSPITAL OF BREMEN for the cost reporting period beginning 05/01/2011 and ending 04/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	21,371	108,742	0	331,530	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	-56,023	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	-34,652	108,742	0	331,530	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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PART I - COST REPORT STATUS

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

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 5. Cost Report Status
 (1) As Submitted
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 (3) Settled with Audit
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 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 9/27/2012 Time: 2:55 pm

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Encryption Information
 ECR: Date: 9/27/2012 Time: 2:55 pm
 Bj9872mbumLVzfhcZ.ou6h3BPCaYFO
 5rmSm0Rj djYS5A9gWI ef4: 5xYkDThP
 kLIh0IR: rJ0Zesp:
 PI: Date: 9/27/2012 Time: 2:55 pm
 2148X5zHy30vwOKi XIal8kkPOCI Tf0
 09lwo0vkVyJRGa2sUHstMjKNmY1pzx
 tbHwPYGQo60eLz1m

(Signed) _____
 Officer or Administrator of Provider(s)

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	21,371	108,742	0	331,530	1.00
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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	-56,023	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	-34,652	108,742	0	331,530	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300			Period: From 05/01/2011 To 04/30/2012		Worksheet S-2 Part I Date/Time Prepared: 9/27/2012 1:30 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1020 HIGH RD			PO Box: 1506						1.00	
2.00	City: BREMEN			State: IN		Zip Code: 46506-		County: MARSHALL		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	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		COMMUNITY HOSPITAL OF BREMEN	151300	99915	1	07/01/1966	0	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		COMMUNITY HOSPITAL SWING BED	15Z300	99915		05/01/1984	N	0	N	7.00
8.00	Swing Beds - NF							N		N	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							N	N	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC							N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1										17.00
17.10	Hospital-Based (CORF) 1										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)						05/01/2011	04/30/2012		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N	N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid 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 days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible 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	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	
							Beginning:	Ending:			
							1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscriber line 36 for number of periods in excess of one and enter subsequent dates.									36.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet S-2 Part I Date/Time Prepared: 9/27/2012 1:30 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. 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. (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
		V		XIX	
		1.00		2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical		Speech	
		Occupational		Respiratory	
		1.00		2.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
		1.00		2.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N			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: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet S-2 Part I Date/Time Prepared: 9/27/2012 1:30 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	152,072	0		118.01
				1.00	2.00
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N	145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	157.00
158.00	SUBPROVIDER				158.00
159.00	SNF	N	N	N	159.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet S-2 Part I Date/Time Prepared: 9/27/2012 1:30 pm		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00			
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
161.10	CORF		N	N	N		161.10	
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	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: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet S-2 Part II Date/Time Prepared: 9/27/2012 1:30 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/17/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet S-2 Part II Date/Time Prepared: 9/27/2012 1:30 pm
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		Part A		
		Description	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
				1.00
				2.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STACEY	THOMAS	41.00
42.00	Enter the employer/company name of the cost report preparer.	STACEY THOMAS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	260-432-8870	STHOMAS797@AOL.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/17/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Avai lable		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	36,264.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					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)		25	9,150	36,264.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,150	36,264.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				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				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
28.02 SUBPROVIDER - IRF	41.00				28.02
28.03 SUBPROVIDER	42.00				28.03
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	537	134	1,019		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	377	0	377		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	115		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	914	134	1,511		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT	0	0	0	0		9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0	0		10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		62	147		13.00
14.00 Total (see instructions)	0	914	196	1,658		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0		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	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	263		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	174	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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	108.76	0.00	0	174	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			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	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	108.76	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	76	354		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				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)	76	354		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	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				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
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: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet S-10 Date/Time Prepared: 9/27/2012 1:30 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.519002	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		439,111	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	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		2,089,941	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,084,684	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)		645,573	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		645,573	19.00	
			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	820,804	0	820,804	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	425,999	0	425,999	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)	425,999	0	425,999	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		157,847	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		93,307	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		64,540	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		33,496	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		459,495	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,105,068	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	1,775,953	1,775,953	1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00	
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS	72,288	39,832	112,120	1,338,110	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	892,770	4,771,570	5,664,340	-3,443,010	5.00	
7.00	00702	OPERATION OF PLANT	159,809	151,485	311,294	309,109	7.00	
7.01	00701	OPERATION OF PLANT	0	0	0	0	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	0	134,027	134,027	0	8.00	
9.00	00901	HOUSEKEEPING	160,075	22,002	182,077	0	9.00	
10.00	01000	DIETARY	199,626	220,124	419,750	-245,788	10.00	
11.00	01100	CAFETERIA	0	0	0	245,788	11.00	
13.00	01300	NURSING ADMINISTRATION	211,654	14,395	226,049	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	200,467	48,432	248,899	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	672,945	133,718	806,663	-31,605	775,058	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	5,011	5,011	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	621,003	1,114,732	1,735,735	-371,569	1,364,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,519	6,519	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	459,945	331,510	791,455	10,263	801,718	54.00
57.00	05700	CT SCAN	10,783	179,739	190,522	0	190,522	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,688	147,568	157,256	0	157,256	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	469,902	641,844	1,111,746	-260	1,111,486	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	14,350	14,350	5,275	19,625	65.00
66.00	06600	PHYSICAL THERAPY	230,863	10,703	241,566	-6,949	234,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,185	4,185	68.00
69.00	06900	ELECTROCARDIOLOGY	0	57,827	57,827	0	57,827	69.00
69.02	06902	SLEEP LAB	0	52,950	52,950	0	52,950	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,967	25,966	121,933	411,585	533,518	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,581	249,735	445,316	0	445,316	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,284,304	155,369	1,439,673	-9,694	1,429,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
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
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,947,670	8,517,878	14,465,548	2,923	14,468,471	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	46,516	60,239	106,755	-2,923	103,832	192.00
200.00		TOTAL (SUM OF LINES 118-199)	5,994,186	8,578,117	14,572,303	0	14,572,303	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-15,046	1,760,907	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	0	1,450,230	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-625,274	1,596,056	5.00
7.00	00702 OPERATION OF PLANT	-4,925	615,478	7.00
7.01	00701 OPERATION OF PLANT	0	0	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	134,027	8.00
9.00	00901 HOUSEKEEPING	-2,137	179,940	9.00
10.00	01000 DIETARY	-10,602	163,360	10.00
11.00	01100 CAFETERIA	-89,343	156,445	11.00
13.00	01300 NURSING ADMINISTRATION	0	226,049	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5,761	243,138	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-8,400	766,658	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	5,011	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-449,120	915,046	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,519	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-1,918	799,800	54.00
57.00	05700 CT SCAN	0	190,522	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	157,256	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	1,111,486	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	19,625	65.00
66.00	06600 PHYSICAL THERAPY	0	234,617	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	4,185	68.00
69.00	06900 ELECTROCARDIOLOGY	0	57,827	69.00
69.02	06902 SLEEP LAB	0	52,950	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-15,714	517,804	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	445,316	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	-892,668	537,311	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
99.10	09910 CORF	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
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
112.00	08600 OTHER ORGAN ACQUISITION	0	0	112.00
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,120,908	12,347,563	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	103,832	192.00
200.00	TOTAL (SUM OF LINES 118-199)	-2,120,908	12,451,395	200.00

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-6
Date/Time Prepared:
9/27/2012 1:30 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - UNASSIGNED COSTS					
1.00	EMPLOYEE BENEFITS	4.00	0	1,338,110	1.00
2.00	OPERATION OF PLANT	7.00	0	309,109	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,126,419	3.00
	TOTALS		0	2,773,638	
B - NURSING					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	5,166	1,353	1.00
2.00	NURSERY	43.00	3,971	1,040	2.00
3.00	RESPIRATORY THERAPY	65.00	4,182	1,093	3.00
	TOTALS		13,319	3,486	
C - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	116,893	128,895	1.00
	TOTALS		116,893	128,895	
D - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	649,534	1.00
2.00	OPERATING ROOM	50.00	0	1,482	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,279	3.00
	TOTALS		0	672,295	
E - SPEECH PURCHASED SVC					
1.00	SPEECH PATHOLOGY	68.00	0	4,185	1.00
	TOTALS		0	4,185	
F - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	411,585	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	411,585	
G - YELLOW PAGES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,923	1.00
	TOTALS		0	2,923	
500.00	Grand Total: Increases		130,212	3,997,007	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - UNASSIGNED COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,773,638	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			0	2,773,638			
B - NURSING							
1.00	ADULTS & PEDIATRICS	30.00	13,319	3,486	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			13,319	3,486			
C - CAFETERIA COSTS							
1.00	DIETARY	10.00	116,893	128,895	0		1.00
TOTALS			116,893	128,895			
D - INTEREST							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	672,295	10		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			0	672,295			
E - SPEECH PURCHASED SVC							
1.00	PHYSICAL THERAPY	66.00	0	4,185	0		1.00
TOTALS			0	4,185			
F - CHARGABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	14,800	0		1.00
2.00	OPERATING ROOM	50.00	0	373,051	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,016	0		3.00
4.00	LABORATORY	60.00	0	260	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	2,764	0		5.00
6.00	EMERGENCY	91.00	0	9,694	0		6.00
TOTALS			0	411,585			
G - YELLOW PAGES							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,923	0		1.00
TOTALS			0	2,923			
500.00	Grand Total: Decreases		130,212	3,997,007			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
9/27/2012 1:30 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	440,039	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,263,776	21,593	0	21,593	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	5,796,883	456,094	0	456,094	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,500,698	477,687	0	477,687	0	8.00
9.00	Reconciling Items	-246,387	-680,853	0	-680,853	0	9.00
10.00	Total (line 8 minus line 9)	23,747,085	1,158,540	0	1,158,540	0	10.00
SUMMARY OF CAPITAL							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	Insurance		
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)			
	1.00	2.00	3.00	4.00			5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
9/27/2012 1:30 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	440,039	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	17,285,369	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	6,252,977	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	23,978,385	0		8.00		
9.00	Reconciling Items	-927,240	0		9.00		
10.00	Total (line 8 minus line 9)	24,905,625	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	0		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,111,373	649,534	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,111,373	649,534	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,760,907	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,760,907	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-8

Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)	B	-18,670	ADMINISTRATIVE & GENERAL		5.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-44,669	ADMINISTRATIVE & GENERAL		5.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-2,984	ADMINISTRATIVE & GENERAL		5.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,350,038				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-89,343	CAFETERIA		11.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-15,714	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-5,761	MEDICAL RECORDS & LIBRARY		16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-4,732	ADMINISTRATIVE & GENERAL		5.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	32.00
33.00 MEALS ON WHEELS	B	-10,602	DIETARY		10.00	33.00
34.00 PRENATAL CLASS	B	-150	ADULTS & PEDIATRICS		30.00	34.00
35.00 INVOICE PENALTIES	A	-4,993	ADMINISTRATIVE & GENERAL		5.00	35.00
36.00 RECRUITING/MD SUPPORT	A	-53,382	ADMINISTRATIVE & GENERAL		5.00	36.00
37.00 LOBBYING EXP IN DUES	A	-1,326	ADMINISTRATIVE & GENERAL		5.00	37.00
38.00 PLYMOUTH ST CLINIC DEPR	A	-15,046	NEW CAP REL COSTS-BLDG & FIXT		1.00	38.00
39.00 ADMIN ADVERTISING/YE CLOSEOUT	A	-140,945	ADMINISTRATIVE & GENERAL		5.00	39.00
40.00 MISC INCOME	B	-26,305	ADMINISTRATIVE & GENERAL		5.00	40.00
41.00 PLYMOUTH ST MAINTENANCE	A	-4,925	OPERATION OF PLANT		7.00	41.00
42.00 PLYMOUTH ST HOUSEKEEPING	A	-2,137	HOUSEKEEPING		9.00	42.00
43.00 HAF PROVIDER ASSESSMENT	A	-327,268	ADMINISTRATIVE & GENERAL		5.00	43.00
44.00 FILM COPIES	B	-1,918	RADIOLOGY-DIAGNOSTIC		54.00	44.00
45.00		0			0.00	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,120,908				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-8

Date/Time Prepared:
9/27/2012 1:30 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-8-2

Date/Time Prepared:
9/27/2012 1:30 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	OPERATING ROOM	449,120	449,120	1.00
2.00	91.00	EMERGENCY	892,668	892,668	2.00
3.00	60.00	LABORATORY	21,600	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	8,250	8,250	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,371,638	1,350,038	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-8-2

Date/Time Prepared:
9/27/2012 1:30 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	21,600	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	21,600			0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-8-2

Date/Time Prepared:
9/27/2012 1:30 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet A-8-2

Date/Time Prepared:
9/27/2012 1:30 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	449,120	1.00
2.00	0	892,668	2.00
3.00	0	0	3.00
4.00	0	8,250	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,350,038	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet A-8-3 Part Date/Time Prepared: 9/27/2012 1:30 pm	
		Speech Pathology		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					10	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					9.77	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	39.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	19.52	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)	9.76	9.76	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	
Part II - SALARY EQUIVALENCY COMPUTATION							
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)					761	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)					761	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)					761	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					19.51	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					2,927	22.00
23.00	Total salary equivalency (see instructions)					2,927	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					98	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)					98	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)					98	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					196	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
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
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151300				Period: From 05/01/2011 To 04/30/2012	Worksheet A-8-3 Part Date/Time Prepared: 9/27/2012 1:30 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	
PART V - OVERTIME COMPUTATION							
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)	6.29	0.00	0.00	0.00	6.29	47.00
48.00	Overtime rate (see instructions)	29.28	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	184.17	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
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)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	40.00	0.00	0.00	0.00	40.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	19.52	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	781	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	184	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	123	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.)	61	0	0	0	61	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					2,927	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					61	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)					2,988	63.00
64.00	Total cost of outside supplier services (from your records)					2,462	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					98	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					98	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					196	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					98	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					98	101.02
LINE 35 CALCULATION							
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: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,760,907	1,760,907			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS	1,450,230	6,585	0	1,456,815	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,596,056	146,890	0	219,626	1,962,572 5.00
7.00 00702	OPERATION OF PLANT	615,478	317,809	0	39,314	972,601 7.00
7.01 00701	OPERATION OF PLANT	0	0	0	0	0 7.01
8.00 00800	LAUNDRY & LINEN SERVICE	134,027	6,271	0	0	140,298 8.00
9.00 00901	HOUSEKEEPING	179,940	10,775	0	39,379	230,094 9.00
10.00 01000	DIETARY	163,360	36,003	0	20,353	219,716 10.00
11.00 01100	CAFETERIA	156,445	35,803	0	28,756	221,004 11.00
13.00 01300	NURSING ADMINISTRATION	226,049	11,374	0	52,068	289,491 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	243,138	18,871	0	49,316	311,325 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	766,658	356,975	0	162,271	1,285,904 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
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	5,011	8,324	0	977	14,312 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	915,046	238,279	0	152,770	1,306,095 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,519	0	0	1,271	7,790 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	799,800	113,538	0	113,149	1,026,487 54.00
57.00 05700	CT SCAN	190,522	0	0	2,653	193,175 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	157,256	0	0	2,383	159,639 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	1,111,486	68,699	0	115,598	1,295,783 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	19,625	0	0	1,029	20,654 65.00
66.00 06600	PHYSICAL THERAPY	234,617	80,272	0	56,793	371,682 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	4,185	0	0	0	4,185 68.00
69.00 06900	ELECTROCARDIOLOGY	57,827	2,052	0	0	59,879 69.00
69.02 06902	SLEEP LAB	52,950	12,799	0	0	65,749 69.02
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	517,804	60,603	0	23,608	602,015 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	445,316	22,776	0	48,114	516,206 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	537,311	194,237	0	315,944	1,047,492 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
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
112.00 08600	OTHER ORGAN ACQUISITION	0	0	0	0	0 112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,347,563	1,748,935	0	1,445,372	12,324,148 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,972	0	0	11,972 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	103,832	0	0	11,443	115,275 192.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	12,451,395	1,760,907	0	1,456,815	12,451,395 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	7.00	7.01	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,962,572				5.00	
7.00	00702	OPERATION OF PLANT	181,984	1,154,585			7.00	
7.01	00701	OPERATION OF PLANT	0	0	0		7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	26,251	5,615	0	172,164	8.00	
9.00	00901	HOUSEKEEPING	43,053	9,647	0	13,289	296,083	9.00
10.00	01000	DIETARY	41,111	32,233	0	445	8,377	10.00
11.00	01100	CAFETERIA	41,352	32,054	0	509	8,330	11.00
13.00	01300	NURSING ADMINISTRATION	54,167	10,183	0	0	2,646	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,252	16,895	0	0	4,391	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	240,607	319,596	0	48,966	83,054	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	2,678	7,452	0	262	1,937	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	244,384	213,328	0	51,981	55,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,458	0	0	342	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	192,067	101,649	0	16,868	26,416	54.00
57.00	05700	CT SCAN	36,145	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	29,870	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	242,455	61,505	0	0	15,984	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,865	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	69,546	71,866	0	10,514	18,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	783	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,204	1,837	0	620	478	69.00
69.02	06902	SLEEP LAB	12,302	11,459	0	374	2,978	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,644	54,257	0	0	14,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,588	20,391	0	0	5,299	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	195,997	173,899	0	25,751	45,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
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
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,938,763	1,143,866	0	169,921	293,297	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,240	10,719	0	0	2,786	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,569	0	0	2,243	0	192.00
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)	1,962,572	1,154,585	0	172,164	296,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
		10.00	11.00	13.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00702						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00901						9.00
10.00	01000	301,882					10.00
11.00	01100	0	303,249				11.00
13.00	01300	0	15,330	371,817			13.00
16.00	01600	0	26,603	0	417,466		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	301,882	43,912	119,483	43,484	2,486,888	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	1,308	3,560	2,102	33,611	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	50,212	136,627	88,629	2,146,695	50.00
52.00	05200	0	1,701	4,627	2,515	18,433	52.00
54.00	05400	0	38,915	0	40,928	1,443,330	54.00
57.00	05700	0	823	0	41,277	271,420	57.00
58.00	05800	0	633	0	17,405	207,547	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	48,463	0	88,069	1,752,259	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	1,376	3,745	3,106	32,746	65.00
66.00	06600	0	15,461	0	17,380	575,125	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	276	5,244	68.00
69.00	06900	0	0	0	7,557	81,575	69.00
69.02	06902	0	0	0	3,560	96,422	69.02
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	11,913	0	16,179	811,108	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	8,460	0	20,376	667,320	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	38,139	103,775	24,623	1,654,868	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
118.00		301,882	303,249	371,817	417,466	12,284,591	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	27,717	190.00
192.00	19200	0	0	0	0	139,087	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		301,882	303,249	371,817	417,466	12,451,395	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00702	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00901	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,486,888	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
32.00	03200	CORONARY CARE UNIT	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	33,611	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,146,695	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,433	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,443,330	54.00
57.00	05700	CT SCAN	271,420	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,547	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	1,752,259	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	32,746	65.00
66.00	06600	PHYSICAL THERAPY	575,125	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,244	68.00
69.00	06900	ELECTROCARDIOLOGY	81,575	69.00
69.02	06902	SLEEP LAB	96,422	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	811,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	667,320	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	1,654,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
99.10	09910	CORF	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION	0	112.00
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,284,591	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,717	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	139,087	192.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	12,451,395	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2. 00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	6,585	0	6,585	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	146,890	0	146,890	5.00
7.00 00702	OPERATION OF PLANT	0	317,809	0	317,809	7.00
7.01 00701	OPERATION OF PLANT	0	0	0	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,271	0	6,271	8.00
9.00 00901	HOUSEKEEPING	0	10,775	0	10,775	9.00
10.00 01000	DIETARY	0	36,003	0	36,003	10.00
11.00 01100	CAFETERIA	0	35,803	0	35,803	11.00
13.00 01300	NURSING ADMINISTRATION	0	11,374	0	11,374	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,871	0	18,871	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	356,975	0	356,975	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	8,324	0	8,324	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	238,279	0	238,279	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	113,538	0	113,538	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	68,699	0	68,699	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	80,272	0	80,272	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	2,052	0	2,052	69.00
69.02 06902	SLEEP LAB	0	12,799	0	12,799	69.02
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60,603	0	60,603	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	22,776	0	22,776	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	194,237	0	194,237	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
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
112.00 08600	OTHER ORGAN ACQUISITION	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,748,935	0	1,748,935	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,972	0	11,972	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
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	1,760,907	0	1,760,907	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	147,883					5.00
7.00	00702	13,713	331,700				7.00
7.01	00701	0	0	0			7.01
8.00	00800	1,978	1,613	0	9,862		8.00
9.00	00901	3,244	2,771	0	761	17,729	9.00
10.00	01000	3,098	9,260	0	26	502	10.00
11.00	01100	3,116	9,209	0	29	499	11.00
13.00	01300	4,082	2,925	0	0	158	13.00
16.00	01600	4,389	4,854	0	0	263	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,130	91,817	0	2,805	4,973	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	202	2,141	0	15	116	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,415	61,287	0	2,978	3,320	50.00
52.00	05200	110	0	0	20	0	52.00
54.00	05400	14,472	29,203	0	966	1,582	54.00
57.00	05700	2,724	0	0	0	0	57.00
58.00	05800	2,251	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	18,269	17,670	0	0	957	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	291	0	0	0	0	65.00
66.00	06600	5,240	20,646	0	602	1,118	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	59	0	0	0	0	68.00
69.00	06900	844	528	0	36	29	69.00
69.02	06902	927	3,292	0	21	178	69.02
70.00	07000	0	0	0	0	0	70.00
71.00	07100	8,488	15,588	0	0	844	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	7,278	5,858	0	0	317	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	14,769	49,959	0	1,475	2,706	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	0	0	0	0	0	112.00
113.00	11300						113.00
118.00		146,089	328,621	0	9,734	17,562	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	169	3,079	0	0	167	190.00
192.00	19200	1,625	0	0	128	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		147,883	331,700	0	9,862	17,729	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
		10.00	11.00	13.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00702						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00901						9.00
10.00	01000	48,981					10.00
11.00	01100	0	48,786				11.00
13.00	01300	0	2,466	21,240			13.00
16.00	01600	0	4,280	0	32,880		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	48,981	7,064	6,825	3,425	541,729	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	210	203	166	11,381	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	8,079	7,806	6,979	347,834	50.00
52.00	05200	0	274	264	198	872	52.00
54.00	05400	0	6,261	0	3,224	169,757	54.00
57.00	05700	0	132	0	3,251	6,119	57.00
58.00	05800	0	102	0	1,371	3,735	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	7,797	0	6,937	120,852	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	221	214	245	976	65.00
66.00	06600	0	2,487	0	1,369	111,991	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	22	81	68.00
69.00	06900	0	0	0	595	4,084	69.00
69.02	06902	0	0	0	280	17,497	69.02
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	1,916	0	1,274	88,820	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	1,361	0	1,605	39,412	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	6,136	5,928	1,939	278,575	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
118.00		48,981	48,786	21,240	32,880	1,743,715	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	15,387	190.00
192.00	19200	0	0	0	0	1,805	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		48,981	48,786	21,240	32,880	1,760,907	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00702	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00901	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	541,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
32.00	03200	CORONARY CARE UNIT	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	11,381	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	347,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	872	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,757	54.00
57.00	05700	CT SCAN	6,119	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,735	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	120,852	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	976	65.00
66.00	06600	PHYSICAL THERAPY	111,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	81	68.00
69.00	06900	ELECTROCARDIOLOGY	4,084	69.00
69.02	06902	SLEEP LAB	17,497	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,412	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	278,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
99.10	09910	CORF	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION	0	112.00
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,743,715	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,387	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,805	192.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	1,760,907	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B-1
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	61,774					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		61,774				2.00
4.00 00400	EMPLOYEE BENEFITS	231	231	5,921,898			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,153	5,153	892,770	-1,962,572	10,488,823	5.00
7.00 00702	OPERATION OF PLANT	11,149	11,149	159,809	0	972,601	7.00
7.01 00701	OPERATION OF PLANT	0	0	0	0	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	220	220	0	0	140,298	8.00
9.00 00901	HOUSEKEEPING	378	378	160,075	0	230,094	9.00
10.00 01000	DIETARY	1,263	1,263	82,733	0	219,716	10.00
11.00 01100	CAFETERIA	1,256	1,256	116,893	0	221,004	11.00
13.00 01300	NURSING ADMINISTRATION	399	399	211,654	0	289,491	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	662	662	200,467	0	311,325	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	12,523	12,523	659,626	0	1,285,904	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	292	292	3,971	0	14,312	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	8,359	8,359	621,003	0	1,306,095	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	5,166	0	7,790	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,983	3,983	459,945	0	1,026,487	54.00
57.00 05700	CT SCAN	0	0	10,783	0	193,175	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	9,688	0	159,639	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,410	2,410	469,902	0	1,295,783	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	4,182	0	20,654	65.00
66.00 06600	PHYSICAL THERAPY	2,816	2,816	230,863	0	371,682	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	4,185	68.00
69.00 06900	ELECTROCARDIOLOGY	72	72	0	0	59,879	69.00
69.02 06902	SLEEP LAB	449	449	0	0	65,749	69.02
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,126	2,126	95,967	0	602,015	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	799	799	195,581	0	516,206	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	6,814	6,814	1,284,304	0	1,047,492	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00 08600	OTHER ORGAN ACQUISITION	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	61,354	61,354	5,875,382	-1,962,572	10,361,576	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	420	0	0	11,972	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	46,516	0	115,275	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,760,907	0	1,456,815		1,962,572	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	28.505633	0.000000	0.246005		0.187111	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			6,585		147,883	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001112		0.014099	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B-1
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT (SQ FT PLYMOUTH ST)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00702	OPERATION OF PLANT	45,241				7.00
7.01	00701	OPERATION OF PLANT	0	0			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	220	0	21,648		8.00
9.00	00901	HOUSEKEEPING	378	0	1,671	44,643	9.00
10.00	01000	DIETARY	1,263	0	56	1,263	100
11.00	01100	CAFETERIA	1,256	0	64	1,256	0
13.00	01300	NURSING ADMINISTRATION	399	0	0	399	0
16.00	01600	MEDICAL RECORDS & LIBRARY	662	0	0	662	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,523	0	6,157	12,523	100
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	292	0	33	292	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,359	0	6,536	8,359	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	43	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,983	0	2,121	3,983	0
57.00	05700	CT SCAN	0	0	0	0	0
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	2,410	0	0	2,410	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	2,816	0	1,322	2,816	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	72	0	78	72	0
69.02	06902	SLEEP LAB	449	0	47	449	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,126	0	0	2,126	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	799	0	0	799	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	6,814	0	3,238	6,814	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,821	0	21,366	44,223	100
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	0	0	420	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	282	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,154,585	0	172,164	296,083	301,882
203.00		Unit cost multiplier (Wkst. B, Part I)	25.520767	0.000000	7.952882	6.632238	3,018.820000
204.00		Cost to be allocated (per Wkst. B, Part II)	331,700	0	9,862	17,729	48,981
205.00		Unit cost multiplier (Wkst. B, Part II)	7.331845	0.000000	0.455562	0.397128	489.810000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet B-1
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		CAFETERIA (FTE HRS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00702 OPERATION OF PLANT				7.00
7.01	00701 OPERATION OF PLANT				7.01
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00901 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA	133,745			11.00
13.00	01300 NURSING ADMINISTRATION	6,761	60,268		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	11,733	0	24,429,250	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	19,367	19,367	2,544,536	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
43.00	04300 NURSERY	577	577	122,983	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	22,146	22,146	5,186,689	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	750	750	147,151	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	17,163	0	2,394,964	54.00
57.00	05700 CT SCAN	363	0	2,415,427	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	279	0	1,018,515	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	21,374	0	5,153,522	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	607	607	181,746	65.00
66.00	06600 PHYSICAL THERAPY	6,819	0	1,017,026	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	16,159	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	442,229	69.00
69.02	06902 SLEEP LAB	0	0	208,301	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,254	0	946,744	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,731	0	1,192,367	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	16,821	16,821	1,440,891	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
99.10	09910 CORF	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
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
112.00	08600 OTHER ORGAN ACQUISITION	0	0	0	112.00
113.00	11300 INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	133,745	60,268	24,429,250	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	303,249	371,817	417,466	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.267367	6.169393	0.017089	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	48,786	21,240	32,880	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.364769	0.352426	0.001346	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Title XVIIII		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance			Total Costs
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,486,888		2,486,888	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
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	33,611		33,611	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,146,695		2,146,695	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,433		18,433	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,443,330		1,443,330	0	0	54.00
57.00	05700	CT SCAN	271,420		271,420	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,547		207,547	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,752,259		1,752,259	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	32,746	0	32,746	0	0	65.00
66.00	06600	PHYSICAL THERAPY	575,125	0	575,125	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,244	0	5,244	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	81,575		81,575	0	0	69.00
69.02	06902	SLEEP LAB	96,422		96,422	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	811,108		811,108	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	667,320		667,320	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,654,868		1,654,868	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	394,245		394,245	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
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
112.00	08600	OTHER ORGAN ACQUISITION	0		0	0	0	112.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,678,836	0	12,678,836	0	0	200.00
201.00		Less Observation Beds	394,245		394,245			201.00
202.00		Total (see instructions)	12,284,591	0	12,284,591	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,186,197		2,186,197		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	122,983		122,983		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	914,409	4,272,280	5,186,689	0.413885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,151	0	147,151	0.125266	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,568	2,314,396	2,394,964	0.602652	54.00
57.00	05700	CT SCAN	156,215	2,259,212	2,415,427	0.112369	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,478	995,037	1,018,515	0.203774	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	497,388	4,656,134	5,153,522	0.340012	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	138,599	43,147	181,746	0.180175	65.00
66.00	06600	PHYSICAL THERAPY	368,303	648,723	1,017,026	0.565497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,462	697	16,159	0.324525	68.00
69.00	06900	ELECTROCARDIOLOGY	60,461	381,768	442,229	0.184463	69.00
69.02	06902	SLEEP LAB	0	208,301	208,301	0.462897	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	421,721	525,023	946,744	0.856734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544,766	647,601	1,192,367	0.559660	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	40,013	1,400,878	1,440,891	1.148503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	358,339	1.100201	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,717,714	18,711,536	24,429,250		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,717,714	18,711,536	24,429,250		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet C Part I Date/Time Prepared: 9/27/2012 1:30 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
32.00	03200	CORONARY CARE UNIT		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
41.00	04100	SUBPROVIDER - I RF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.02	06902	SLEEP LAB	0.000000	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
112.00	08600	OTHER ORGAN ACQUISITION		112.00
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
			1.00	2.00	3.00		4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,486,888		2,486,888	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
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	33,611		33,611	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,146,695		2,146,695	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,433		18,433	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,443,330		1,443,330	0	0	54.00
57.00	05700	CT SCAN	271,420		271,420	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,547		207,547	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,752,259		1,752,259	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	32,746	0	32,746	0	0	65.00
66.00	06600	PHYSICAL THERAPY	575,125	0	575,125	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,244	0	5,244	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	81,575		81,575	0	0	69.00
69.02	06902	SLEEP LAB	96,422		96,422	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	811,108		811,108	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	667,320		667,320	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,654,868		1,654,868	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	394,245		394,245	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
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
112.00	08600	OTHER ORGAN ACQUISITION	0		0	0	0	112.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,678,836	0	12,678,836	0	0	200.00
201.00		Less Observation Beds	394,245		394,245			201.00
202.00		Total (see instructions)	12,284,591	0	12,284,591	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,186,197		2,186,197		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	122,983		122,983		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	914,409	4,272,280	5,186,689	0.413885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,151	0	147,151	0.125266	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,568	2,314,396	2,394,964	0.602652	54.00
57.00	05700	CT SCAN	156,215	2,259,212	2,415,427	0.112369	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,478	995,037	1,018,515	0.203774	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	497,388	4,656,134	5,153,522	0.340012	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	138,599	43,147	181,746	0.180175	65.00
66.00	06600	PHYSICAL THERAPY	368,303	648,723	1,017,026	0.565497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,462	697	16,159	0.324525	68.00
69.00	06900	ELECTROCARDIOLOGY	60,461	381,768	442,229	0.184463	69.00
69.02	06902	SLEEP LAB	0	208,301	208,301	0.462897	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	421,721	525,023	946,744	0.856734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544,766	647,601	1,192,367	0.559660	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	40,013	1,400,878	1,440,891	1.148503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	358,339	1.100201	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,717,714	18,711,536	24,429,250		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,717,714	18,711,536	24,429,250		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet C Part I Date/Time Prepared: 9/27/2012 1:30 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
32.00	03200	CORONARY CARE UNIT		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
41.00	04100	SUBPROVIDER - I RF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERV		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.02	06902	SLEEP LAB	0.000000	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
112.00	08600	OTHER ORGAN ACQUISITION		112.00
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 151300

Period: From 05/01/2011 To 04/30/2012

Worksheet C Part II Date/Time Prepared: 9/27/2012 1:30 pm

Cost Center Description		Title XIX Hospital Cost				
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,146,695	347,834	1,798,861	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	18,433	872	17,561	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,443,330	169,757	1,273,573	0	0
57.00	05700 CT SCAN	271,420	6,119	265,301	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	207,547	3,735	203,812	0	0
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000 LABORATORY	1,752,259	120,852	1,631,407	0	0
60.01	06001 BLOOD LABORATORY	0	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	32,746	976	31,770	0	0
66.00	06600 PHYSICAL THERAPY	575,125	111,991	463,134	0	0
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	5,244	81	5,163	0	0
69.00	06900 ELECTROCARDIOLOGY	81,575	4,084	77,491	0	0
69.02	06902 SLEEP LAB	96,422	17,497	78,925	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	811,108	88,820	722,288	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	667,320	39,412	627,908	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000 CLINIC	0	0	0	0	0
91.00	09100 EMERGENCY	1,654,868	278,575	1,376,293	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	394,245	0	394,245	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0
99.10	09910 CORF	0	0	0	0	0
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
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
112.00	08600 OTHER ORGAN ACQUISITION	0	0	0	0	0
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	10,158,337	1,190,605	8,967,732	0	0
201.00	Less Observation Beds	394,245	0	394,245	0	0
202.00	Total (line 200 minus line 201)	9,764,092	1,190,605	8,573,487	0	0

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

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2,146,695	5,186,689	0.413885	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	18,433	147,151	0.125266	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,443,330	2,394,964	0.602652	54.00
57.00	05700 CT SCAN	271,420	2,415,427	0.112369	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	207,547	1,018,515	0.203774	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000 LABORATORY	1,752,259	5,153,522	0.340012	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	32,746	181,746	0.180175	65.00
66.00	06600 PHYSICAL THERAPY	575,125	1,017,026	0.565497	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	5,244	16,159	0.324525	68.00
69.00	06900 ELECTROCARDIOLOGY	81,575	442,229	0.184463	69.00
69.02	06902 SLEEP LAB	96,422	208,301	0.462897	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	811,108	946,744	0.856734	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	667,320	1,192,367	0.559660	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000 CLINIC	0	0	0.000000	90.00
91.00	09100 EMERGENCY	1,654,868	1,440,891	1.148503	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	394,245	358,339	1.100201	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	95.00
99.10	09910 CORF	0	0	0.000000	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000	110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000	111.00
112.00	08600 OTHER ORGAN ACQUISITION	0	0	0.000000	112.00
113.00	11300 INTEREST EXPENSE	0	0	0.000000	113.00
200.00	Subtotal (sum of lines 50 thru 199)	10,158,337	22,120,070		200.00
201.00	Less Observation Beds	394,245	0		201.00
202.00	Total (line 200 minus line 201)	9,764,092	22,120,070		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Title V		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,486,888	2,486,888	0	0	30.00	
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	31.00	
32.00	03200 CORONARY CARE UNIT	0	0	0	0	32.00	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00	
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	33,611	33,611	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,146,695	2,146,695	0	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	18,433	18,433	0	0	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,443,330	1,443,330	0	0	54.00	
57.00	05700 CT SCAN	271,420	271,420	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	207,547	207,547	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000 LABORATORY	1,752,259	1,752,259	0	0	60.00	
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500 RESPIRATORY THERAPY	32,746	32,746	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	575,125	575,125	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	5,244	5,244	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	81,575	81,575	0	0	69.00	
69.02	06902 SLEEP LAB	96,422	96,422	0	0	69.02	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	811,108	811,108	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	667,320	667,320	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000 CLINIC	0	0	0	0	90.00	
91.00	09100 EMERGENCY	1,654,868	1,654,868	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	394,245	394,245	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	95.00	
99.10	09910 CORF	0	0	0	0	99.10	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
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	
112.00	08600 OTHER ORGAN ACQUISITION	0	0	0	0	112.00	
113.00	11300 INTEREST EXPENSE	0	0	0	0	113.00	
200.00	Subtotal (see instructions)	12,678,836	12,678,836	0	0	200.00	
201.00	Less Observation Beds	394,245	394,245	0	0	201.00	
202.00	Total (see instructions)	12,284,591	12,284,591	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet C
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

		Title V			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,186,197		2,186,197		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	122,983		122,983		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	914,409	4,272,280	5,186,689	0.413885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,151	0	147,151	0.125266	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,568	2,314,396	2,394,964	0.602652	54.00
57.00	05700	CT SCAN	156,215	2,259,212	2,415,427	0.112369	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,478	995,037	1,018,515	0.203774	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	497,388	4,656,134	5,153,522	0.340012	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	138,599	43,147	181,746	0.180175	65.00
66.00	06600	PHYSICAL THERAPY	368,303	648,723	1,017,026	0.565497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,462	697	16,159	0.324525	68.00
69.00	06900	ELECTROCARDIOLOGY	60,461	381,768	442,229	0.184463	69.00
69.02	06902	SLEEP LAB	0	208,301	208,301	0.462897	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	421,721	525,023	946,744	0.856734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544,766	647,601	1,192,367	0.559660	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	40,013	1,400,878	1,440,891	1.148503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	358,339	1.100201	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
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
112.00	08600	OTHER ORGAN ACQUISITION	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,717,714	18,711,536	24,429,250		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,717,714	18,711,536	24,429,250		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet C Part I Date/Time Prepared: 9/27/2012 1:30 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title V	Hospital
				Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
32.00	03200	CORONARY CARE UNIT		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
41.00	04100	SUBPROVIDER - I RF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.02	06902	SLEEP LAB	0.000000	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
112.00	08600	OTHER ORGAN ACQUISITION		112.00
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	347,834	5,186,689	0.067063	254,459	17,065	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	872	147,151	0.005926	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	169,757	2,394,964	0.070881	35,112	2,489	54.00
57.00	05700 CT SCAN	6,119	2,415,427	0.002533	66,422	168	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,735	1,018,515	0.003667	6,913	25	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	120,852	5,153,522	0.023450	194,651	4,565	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	976	181,746	0.005370	306	2	65.00
66.00	06600 PHYSICAL THERAPY	111,991	1,017,026	0.110116	76,349	8,407	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	81	16,159	0.005013	6,374	32	68.00
69.00	06900 ELECTROCARDIOLOGY	4,084	442,229	0.009235	22,252	205	69.00
69.02	06902 SLEEP LAB	17,497	208,301	0.083999	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	88,820	946,744	0.093816	180,308	16,916	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39,412	1,192,367	0.033054	292,065	9,654	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	278,575	1,440,891	0.193335	3,583	693	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	1,190,605	22,120,070		1,138,794	60,221	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,186,689	0.000000	0.000000	254,459	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	147,151	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,394,964	0.000000	0.000000	35,112	54.00
57.00	05700	CT SCAN	0	2,415,427	0.000000	0.000000	66,422	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,018,515	0.000000	0.000000	6,913	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,153,522	0.000000	0.000000	194,651	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	181,746	0.000000	0.000000	306	65.00
66.00	06600	PHYSICAL THERAPY	0	1,017,026	0.000000	0.000000	76,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,159	0.000000	0.000000	6,374	68.00
69.00	06900	ELECTROCARDIOLOGY	0	442,229	0.000000	0.000000	22,252	69.00
69.02	06902	SLEEP LAB	0	208,301	0.000000	0.000000	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	946,744	0.000000	0.000000	180,308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,192,367	0.000000	0.000000	292,065	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,440,891	0.000000	0.000000	3,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	22,120,070			1,138,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
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	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
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
69.02	06902 SLEEP LAB	0	0			69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
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
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part V Date/Time Prepared: 9/27/2012 1:30 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges				
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.413885	0	1,002,733	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.125266	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.602652	0	510,169	0	54.00
57.00	05700	CT SCAN	0.112369	0	660,944	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.203774	0	241,026	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.340012	0	1,677,401	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.180175	0	1,525	0	65.00
66.00	06600	PHYSICAL THERAPY	0.565497	0	272,835	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324525	0	302	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184463	0	144,671	0	69.00
69.02	06902	SLEEP LAB	0.462897	0	44,313	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.856734	0	111,578	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.559660	0	299,072	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	1.148503	0	424,124	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.100201	0	144,370	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0		95.00
200.00		Subtotal (see instructions)		0	5,535,063	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	5,535,063	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part V Date/Time Prepared: 9/27/2012 1:30 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	415,016	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	307,454	0	54.00
57.00	05700	CT SCAN	0	74,270	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	49,115	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	570,336	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	275	0	65.00
66.00	06600	PHYSICAL THERAPY	0	154,287	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	98	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,686	0	69.00
69.02	06902	SLEEP LAB	0	20,512	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	95,593	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	167,379	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	487,108	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	158,836	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	2,526,965	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	2,526,965	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151300	Period: From 05/01/2011	Worksheet D
		Component CCN: 15Z300	To 04/30/2012	Part V
		Title XVIII		Date/Time Prepared: 9/27/2012 1:30 pm
		Swing Beds - SNF		Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost		
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.413885	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.125266	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.602652	0	0	0	54.00
57.00	05700	CT SCAN	0.112369	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.203774	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.340012	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.180175	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.565497	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324525	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184463	0	0	0	69.00
69.02	06902	SLEEP LAB	0.462897	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.856734	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.559660	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	1.148503	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.100201	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0		95.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151300	Period: From 05/01/2011	Worksheet D
		Component CCN: 15Z300	To 04/30/2012	Part V
		Title XVIII		Date/Time Prepared: 9/27/2012 1:30 pm
		Swing Beds - SNF		Cost

Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	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	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.02	06902	SLEEP LAB	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part V Date/Time Prepared: 9/27/2012 1:30 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost		
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
			1.00	2.00		3.00	4.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.413885	278,001	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.125266	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.602652	184,173	0	0	54.00
57.00	05700	CT SCAN	0.112369	155,232	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.203774	69,387	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.340012	290,452	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.180175	2,193	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.565497	15,301	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324525	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184463	17,122	0	0	69.00
69.02	06902	SLEEP LAB	0.462897	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.856734	42,093	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.559660	44,775	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	1.148503	344,074	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.100201	87,366	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0		95.00
200.00		Subtotal (see instructions)		1,530,169	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)		1,530,169	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part V Date/Time Prepared: 9/27/2012 1:30 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	115,060	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	110,992	0	0	54.00
57.00	05700 CT SCAN	17,443	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	14,139	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	98,757	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	395	0	0	65.00
66.00	06600 PHYSICAL THERAPY	8,653	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	3,158	0	0	69.00
69.02	06902 SLEEP LAB	0	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	36,063	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,059	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	395,170	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	96,120	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		0		95.00
200.00	Subtotal (see instructions)	805,949	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)	805,949	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part I
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Title V			Hospital	Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	541,729	123,105	418,624	1,282	326.54	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0.00	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	04100 SUBPROVIDER - I RF	0	0	0	0	0.00	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	04300 NURSERY	11,381		11,381	147	77.42	43.00
200.00	Total (lines 30-199)	553,110		430,005	1,429		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part I Date/Time Prepared: 9/27/2012 1:30 pm
		Title V	Hospital	Cost

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
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
200.00	Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part II
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Title V			Hospital	Cost		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	347,834	5,186,689	0.067063	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	872	147,151	0.005926	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,757	2,394,964	0.070881	0	0	54.00
57.00	05700	CT SCAN	6,119	2,415,427	0.002533	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,735	1,018,515	0.003667	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	120,852	5,153,522	0.023450	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	976	181,746	0.005370	0	0	65.00
66.00	06600	PHYSICAL THERAPY	111,991	1,017,026	0.110116	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	81	16,159	0.005013	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,084	442,229	0.009235	0	0	69.00
69.02	06902	SLEEP LAB	17,497	208,301	0.083999	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,820	946,744	0.093816	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,412	1,192,367	0.033054	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	278,575	1,440,891	0.193335	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,190,605	22,120,070		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet D Part III Date/Time Prepared: 9/27/2012 1:30 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	Cost	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet D Part III Date/Time Prepared: 9/27/2012 1:30 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	Cost
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,282	0.00	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	147	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	1,429		0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part III Date/Time Prepared: 9/27/2012 1:30 pm
	Title V	Hospital	Cost

Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	
	12.00	13.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000 ADULTS & PEDIATRICS	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
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
200.00 Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Title V				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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.02	06902	SLEEP LAB	0	0	0	0	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,186,689	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	147,151	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,394,964	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	2,415,427	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,018,515	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	5,153,522	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	181,746	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,017,026	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,159	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	442,229	0.000000	0.000000	0	69.00
69.02	06902	SLEEP LAB	0	208,301	0.000000	0.000000	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	946,744	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,192,367	0.000000	0.000000	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,440,891	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,339	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	22,120,070			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D Part IV Date/Time Prepared: 9/27/2012 1:30 pm
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Cost Center Description	Title V			Hospital		PSA Adj. Non Physician Anesthetist Cost	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			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
69.02 06902 SLEEP LAB	0	0	0	0	0	0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00 09500 AMBULANCE SERVICES								95.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D
Part IV
Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title V	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
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
69.02	06902 SLEEP LAB	0	0			69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
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
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 9/27/2012 1:30 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,774	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,282	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)		1,019	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		230	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)		147	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		84	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)		31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		537	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)		230	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)		147	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,486,888	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)		565,134	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,921,754	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,787,946	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,787,946	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.074839	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)		1,754.61	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)		1,921,754	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,499.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		804,979	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)		804,979	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet D-1 Date/Time Prepared: 9/27/2012 1:30 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	572,986					
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0					
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0					
52.00	Total Program excludable cost (sum of lines 50 and 51)	0					
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0					
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges	0					
55.00	Target amount per discharge	0.00					
56.00	Target amount (line 54 x line 55)	0					
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0					
58.00	Bonus payment (see instructions)	0					
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					
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00					
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					
62.00	Relief payment (see instructions)	0					
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0					
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	344,777					
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	220,357					
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	565,134					
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					
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					
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	70.00					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	71.00					
72.00	Program routine service cost (line 9 x line 71)	72.00					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	73.00					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	74.00					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	75.00					
76.00	Per diem capital-related costs (line 75 ÷ line 2)	76.00					
77.00	Program capital-related costs (line 9 x line 76)	77.00					
78.00	Inpatient routine service cost (line 74 minus line 77)	78.00					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	79.00					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	80.00					
81.00	Inpatient routine service cost per diem limitation	81.00					
82.00	Inpatient routine service cost limitation (line 9 x line 81)	82.00					
83.00	Reasonable inpatient routine service costs (see instructions)	83.00					
84.00	Program inpatient ancillary services (see instructions)	84.00					
85.00	Utilization review - physician compensation (see instructions)	85.00					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	86.00					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)	263					
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,499.03					
89.00	Observation bed cost (line 87 x line 88) (see instructions)	394,245					

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet D-1 Date/Time Prepared: 9/27/2012 1:30 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 9/27/2012 1:30 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,774	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,282	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)		1,019	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		230	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)		147	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		115	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		134	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)		147	15.00
16.00	Nursery days (title V or XIX only)		62	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,486,888	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)		565,134	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,921,754	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,787,946	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,787,946	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.074839	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)		1,754.61	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)		1,921,754	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,499.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		200,870	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)		200,870	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300		Period: From 05/01/2011 To 04/30/2012		Worksheet D-1	
Title XIX		Hospital		Cost		Date/Time Prepared: 9/27/2012 1:30 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	33,611	147	228.65	62	14,176		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0		44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0		45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0		46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					116,484		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					331,530		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						263	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,499.03	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						394,245	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D-1
Date/Time Prepared:
9/27/2012 1:30 pm

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1
		Title V	Hospital	Date/Time Prepared: 9/27/2012 1:30 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,774	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,282	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)		1,019	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		377	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		115	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	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)		147	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,486,888	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)		565,134	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,921,754	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	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)		0.00	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)		1,921,754	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,499.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1 Date/Time Prepared: 9/27/2012 1:30 pm		
Cost Center Description			Title V		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)	33,611	147	228.65	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					263	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,499.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					394,245	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet D-1

Date/Time Prepared:
9/27/2012 1:30 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-3 Date/Time Prepared: 9/27/2012 1:30 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		711,131		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.413885	254,459	105,317	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.125266	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.602652	35,112	21,160	54.00
57.00	05700 CT SCAN	0.112369	66,422	7,464	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.203774	6,913	1,409	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.340012	194,651	66,184	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.180175	306	55	65.00
66.00	06600 PHYSICAL THERAPY	0.565497	76,349	43,175	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.324525	6,374	2,069	68.00
69.00	06900 ELECTROCARDIOLOGY	0.184463	22,252	4,105	69.00
69.02	06902 SLEEP LAB	0.462897	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.856734	180,308	154,476	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.559660	292,065	163,457	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.148503	3,583	4,115	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.100201	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,138,794	572,986	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,138,794		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151300 Component CCN: 15Z300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-3 Date/Time Prepared: 9/27/2012 1:30 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		140,368	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.413885	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.125266	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.602652	9,266	54.00
57.00	05700	CT SCAN	0.112369	1,382	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.203774	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.340012	49,616	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.180175	0	65.00
66.00	06600	PHYSICAL THERAPY	0.565497	193,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.324525	5,663	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184463	4,249	69.00
69.02	06902	SLEEP LAB	0.462897	0	69.02
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.856734	9,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.559660	112,293	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	1.148503	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.100201	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		385,348	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		385,348	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet D-3 Date/Time Prepared: 9/27/2012 1:30 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		190,972		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		55,393		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.413885	136,311	56,417	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.125266	60,148	7,534	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.602652	2,522	1,520	54.00
57.00	05700 CT SCAN	0.112369	12,973	1,458	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.203774	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.340012	41,572	14,135	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.180175	1,908	344	65.00
66.00	06600 PHYSICAL THERAPY	0.565497	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.324525	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.184463	5,911	1,090	69.00
69.02	06902 SLEEP LAB	0.462897	0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.856734	11,087	9,499	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.559660	31,824	17,811	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.148503	5,813	6,676	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.100201	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		310,069	116,484	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)		310,069		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part B Date/Time Prepared: 9/27/2012 1:30 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,526,965 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,526,965 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,552,235 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			25,606 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			748,589 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,778,040 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,778,040 30.00
31.00	Primary payer payments			2,527 31.00
32.00	Subtotal (line 30 minus line 31)			1,775,513 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			86,484 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			86,484 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			86,484 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,861,997 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,861,997 40.00
41.00	Interim payments			1,753,255 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)			108,742 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			221,159 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part B Date/Time Prepared: 9/27/2012 1:30 pm
		Title XVIII	Hospital Cost
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
9/27/2012 1:30 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		1,103,086		1,617,514	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/09/2012	130,909	01/09/2012	135,741	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		130,909		135,741	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)		1,233,995		1,753,255	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		21,371		108,742	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,255,366		1,861,997	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: 151300
Component CCN: 15Z300

Period:
From 05/01/2011
To 04/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
9/27/2012 1:30 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		621,698		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/09/2012	211,888		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		211,888		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)		833,586		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		56,023		0	6.02
7.00	Total Medicare program liability (see instructions)		777,563		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: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet E-1 Part II Date/Time Prepared: 9/27/2012 1:30 pm
		Title XVIII	Hospital	Cost
				1.00
DATA COLLECTION NEEDED FOR THE HIT CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			354 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			537 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,019 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			24,429,250 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			820,804 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial /interim HIT payment(s)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			0 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151300

Period:

Worksheet E-2

Component CCN: 15Z300

From 05/01/2011
To 04/30/2012

Date/Time Prepared:
9/27/2012 1:30 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Part A	Part B				
		1.00	2.00				
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	570,785	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)	207,486	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	377	375				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)	778,271	0				8.00
9.00	Primary payer payments (see instructions)	0	0				9.00
10.00	Subtotal (line 8 minus line 9)	778,271	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)	778,271	0				12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	708	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)	777,563	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)	777,563	0				19.00
20.00	Interim payments	833,586	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)	-56,023	0				22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	14,971	0				23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part V Date/Time Prepared: 9/27/2012 1:30 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,377,965 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)			1,377,965 4.00
5.00	Primary payer payments			2,795 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,388,950 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,388,950 19.00
20.00	Deductibles (exclude professional component)			140,124 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,248,826 22.00
23.00	Coinsurance			283 23.00
24.00	Subtotal (line 22 minus line 23)			1,248,543 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			6,823 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			6,823 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			6,823 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,255,366 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)			1,255,366 30.00
31.00	Interim payments			1,233,995 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)			21,371 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			28,220 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 9/27/2012 1:30 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		331,530	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)		331,530	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)		331,530	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		1,840,238	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,840,238	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		1,840,238	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,508,708	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		331,530	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		331,530	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		331,530	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		331,530	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		331,530	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)		331,530	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		331,530	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 9/27/2012 1:30 pm
		Title V	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services			0 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)			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)			0 7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges			0 8.00
9.00	Ancillary service charges			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)			0 12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0 13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)			0 16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			0 17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0 18.00
19.00	Interns and Residents (see instructions)			0 19.00
20.00	Cost of Teaching Physicians (see instructions)			0 20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			0 21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments			0 22.00
23.00	Outlier payments			0 23.00
24.00	Program capital payments			0 24.00
25.00	Capital exception payments (see instructions)			0 25.00
26.00	Routine and Ancillary service other pass through costs			0 26.00
27.00	Subtotal (sum of lines 22 through 26)			0 27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0 28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.			0 29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)			0 30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			0 31.00
32.00	Deductibles			0 32.00
33.00	Coinsurance			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Utilization review			0 35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0 36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 37.00
38.00	Subtotal (line 36 ± line 37)			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)			0 40.00
41.00	Interim payments			0 41.00
42.00	Balance due provider/program (line 40 minus 41)			0 42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			0 43.00

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

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet G

Date/Time Prepared:
9/27/2012 1:30 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,076,239	0	0	0	1.00
2.00	Temporary investments	807,360	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,192,586	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,385,503	0	0	0	6.00
7.00	Inventory	127,511	0	0	0	7.00
8.00	Prepaid expenses	551,851	0	0	0	8.00
9.00	Other current assets	41,930	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)	4,411,974	0	0	0	11.00
FIXED ASSETS						
12.00	Land	440,039	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	17,285,369	0	0	0	15.00
16.00	Accumulated depreciation	-2,842,038	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	6,252,977	0	0	0	23.00
24.00	Accumulated depreciation	-4,124,390	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	927,238	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,939,195	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,351,169	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	288,273	0	0	0	37.00
38.00	Salaries, wages, and fees payable	440,051	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	67,895	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	944,672	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,740,891	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	16,269,895	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	348,757	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,618,652	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,359,543	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,991,626				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)	3,991,626	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,351,169	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet G-1

Date/Time Prepared:
9/27/2012 1:30 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		3,850,694	
2.00	Net income (loss) (From Wkst. G-3, line 29)		140,933			2.00
3.00	Total (sum of line 1 and line 2)		3,991,627		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		3,991,627		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,991,627		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet G-1

Date/Time Prepared:
9/27/2012 1:30 pm

	Endowment Fund		Plant Fund			
	5.00	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		0			4.00
5.00	0		0			5.00
6.00	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10)		0		0		11.00
12.00 Deductions (debit adjustments) (specify)	0		0			12.00
13.00	0		0			13.00
14.00	0		0			14.00
15.00	0		0			15.00
16.00	0		0			16.00
17.00	0		0			17.00
18.00 Total deductions (sum of lines 12-17)		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: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet G-2 Parts

Date/Time Prepared:
9/27/2012 1:30 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,064,196		2,064,196	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	243,521		243,521	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)	2,307,717		2,307,717	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,307,717		2,307,717	17.00
18.00	Ancillary services	3,047,259		3,047,259	18.00
19.00	Outpatient services	0	19,961,700	19,961,700	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	0	0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,354,976	19,961,700	25,316,676	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,572,303		29.00
30.00	BAD DEBTS	157,847			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)		157,847		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)		14,730,150		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151300

Period:
From 05/01/2011
To 04/30/2012

Worksheet G-3

Date/Time Prepared:
9/27/2012 1:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	25,316,676	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,096,579	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,220,097	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,730,150	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-510,053	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	330,640	6.00
7.00	Income from investments	18,690	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	47,609	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	89,343	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	15,743	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	5,761	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	MISC	143,200	24.00
25.00	Total other income (sum of lines 6-24)	650,986	25.00
26.00	Total (line 5 plus line 25)	140,933	26.00
27.00		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)	140,933	29.00