

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: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/31/2013 12:09 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/31/2013 Time: 12:09 pm	
	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.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HRH SPECIALTY HOSPITAL ( 153039 ) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V		Title XVIII		HIT	Title XIX	
	1.00	2.00	Part A	Part B			
<b>PART III - SETTLEMENT SUMMARY</b>							
1.00 Hospital	0	26,299		27,101	0	0	1.00
2.00 Subprovider - IPF	0	0		0		0	2.00
3.00 Subprovider - IRF	0	0		0		0	3.00
4.00 SUBPROVIDER I	0	0		0		0	4.00
5.00 Swing bed - SNF	0	0		0		0	5.00
6.00 Swing bed - NF	0	0		0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0		0		0	7.00
8.00 NURSING FACILITY	0	0		0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0		0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0		0		0	11.00
12.00 CMHC I	0	0		0		0	12.00
200.00 Total	0	26,299		27,101	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 12:08 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 829 N. DIXON ROAD	PO Box:		Zip Code: 46901-		County: HOWARD				1.00
2.00	City: KOKOMO	State: IN								2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	COMMUNITY HRH SPECIALTY HOSPITAL	153039	99915	5	04/01/2004	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012	20.00		
21.00	Type of Control (see instructions)					6			21.00	

22.00 Inpatient PPS Information										
22.00 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
1.00	2.00	3.00	4.00	5.00	6.00		
24.00	0	0	0	0	0	0	24.00
25.00	91	0	0	0	48	0	25.00

						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 12:08 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153039

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 12:08 pm		
		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				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)	N	N	0		76.00
		1.00				
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N			80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V		XIX		
		1.00		2.00		
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00			3.00	
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	58,635	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	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
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		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
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		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: HOWARD REGIONAL HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 00130	
142.00	Street: 3500 S. LAFOUNTAIN	PO Box:			
143.00	City: KOKOMO	State:		Zip Code: 46902	
				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	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 12:08 pm	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						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: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/31/2013 12:08 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/30/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/31/2013 12:08 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEANDCO. COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/30/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	30	10,980	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		30	10,980	0.00	0	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)		30	10,980	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	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)		30				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
				I/P Days / O/P Vi s i t s / Tri ps		Full Time Equivalents
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	5,199	91	6,017			1.00
2.00 HMO	44	48				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,199	91	6,017			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)	5,199	91	6,017	0.00	134.17	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	134.17	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
		11.00	12.00	13.00	14.00		15.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	525	9	631	1.00
2.00	HMO			5			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	525	9	631	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					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)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153039

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

Worksheet A  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		218,109	218,109	13,412	231,521	1.00
1.01	00101		27,237	27,237	0	27,237	1.01
4.00	00400						4.00
		-5,603	1,069,288	1,063,685	-3,603	1,060,082	4.00
5.00	00500	1,042,277	1,052,637	2,094,914	-8,844	2,086,070	5.00
7.00	00700	362,046	1,423,573	1,785,619	-463	1,785,156	7.00
8.00	00800	0	37,535	37,535	0	37,535	8.00
9.00	00900	78,457	52,916	131,373	-7,623	123,750	9.00
10.00	01000	197,859	161,059	358,918	-8,325	350,593	10.00
11.00	01100	0	0	0	8,268	8,268	11.00
13.00	01300	0	0	0	73,177	73,177	13.00
16.00	01600	223,742	36,458	260,200	0	260,200	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,216,867	624,504	1,841,371	-451,966	1,389,405	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	4,687	5,346	10,033	13,576	23,609	54.00
54.02	05401	0	0	0	0	0	54.02
57.00	05700	0	0	0	9,522	9,522	57.00
58.00	05800	0	0	0	1,627	1,627	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,467	1,467	236,475	237,942	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	255,135	64,975	320,110	-20,149	299,961	65.00
66.00	06600	3,116,897	758,036	3,874,933	-33,555	3,841,378	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	41,520	8,092	49,612	213,191	262,803	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	259,649	314,505	574,154	5,516	579,670	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	86,730	11,733	98,463	0	98,463	93.02
93.03	04042	382,146	136,085	518,231	-40,236	477,995	93.03
93.04	04043	0	332	332	0	332	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		7,262,409	6,003,887	13,266,296	0	13,266,296	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00		7,262,409	6,003,887	13,266,296	0	13,266,296	200.00
Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	0	231,521				1.00
1.01	00101	0	27,237				1.01
4.00	00400	0	1,060,082				4.00
5.00	00500	404,285	2,490,355				5.00
7.00	00700	0	1,785,156				7.00
8.00	00800	0	37,535				8.00
9.00	00900	0	123,750				9.00
10.00	01000	-1,277	349,316				10.00
11.00	01100	0	8,268				11.00
13.00	01300	0	73,177				13.00
16.00	01600	-1,462	258,738				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	1,389,405				30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	-5,488	18,121				54.00
54.02	05401	0	0				54.02
57.00	05700	-3,849	5,673				57.00
58.00	05800	-672	955				58.00
59.00	05900	0	0				59.00
60.00	06000	-103,074	134,868				60.00
60.01	06001	0	0				60.01
65.00	06500	-5,070	294,891				65.00
66.00	06600	-11,387	3,829,991				66.00
69.00	06900	0	0				69.00
71.00	07100	-741	262,062				71.00
72.00	07200	0	0				72.00
73.00	07300	0	579,670				73.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153039

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

Worksheet A  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	0	98,463	93.02
93.03	04042 SLEEP LAB	-24,134	453,861	93.03
93.04	04043 PHYSICIANS OFFICE	-25,849	-25,517	93.04
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	221,282	13,487,578	118.00
NONREIMBURSABLE COST CENTERS				
200.00	TOTAL (SUM OF LINES 118-199)	221,282	13,487,578	200.00

RECLASSIFICATIONS

Provider CCN: 153039

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

Worksheet A-6

Date/Time Prepared:  
5/31/2013 12:08 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - SUPPLY RECLASS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	207,742	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,568	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
<b>TOTALS</b>			0	212,310	
<b>B - PHARMACY RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,628	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
<b>TOTALS</b>			0	7,628	
<b>C - CAFETERIA RECLASS</b>					
1.00	CAFETERIA	11.00	4,558	3,710	1.00
<b>TOTALS</b>			4,558	3,710	
<b>D - NURSING ADMIN RECLASS</b>					
1.00	NURSING ADMINISTRATION	13.00	73,177	0	1.00
<b>TOTALS</b>			73,177	0	
<b>E - INSURANCE RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,412	1.00
<b>TOTALS</b>			0	13,412	
<b>F - PURCHASED SERVICES RECLASS</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,576	1.00
2.00	CT SCAN	57.00	0	9,522	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,627	3.00
4.00	LABORATORY	60.00	0	236,475	4.00
5.00	RESPIRATORY THERAPY	65.00	0	14,651	5.00
6.00	PHYSICAL THERAPY	66.00	0	5,778	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,449	7.00
<b>TOTALS</b>			0	287,078	
500.00	<b>Grand Total: Increases</b>		77,735	524,138	500.00

RECLASSIFICATIONS

Provider CCN: 153039

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

Worksheet A-6

Date/Time Prepared:  
5/31/2013 12:08 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - SUPPLY RECLASS</b>							
1.00	EMPLOYEE BENEFITS	4.00	0	1,587	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	463	0	2.00	
3.00	HOUSEKEEPING	9.00	0	7,623	0	3.00	
4.00	DIETARY	10.00	0	57	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	88,325	0	5.00	
6.00	RESPIRATORY THERAPY	65.00	0	34,629	0	6.00	
7.00	PHYSICAL THERAPY	66.00	0	37,278	0	7.00	
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,112	0	8.00	
9.00	SLEEP LAB	93.03	0	40,236	0	9.00	
	TOTALS		0	212,310			
<b>B - PHARMACY RECLASS</b>							
1.00	EMPLOYEE BENEFITS	4.00	0	2,016	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	3,386	0	2.00	
3.00	RESPIRATORY THERAPY	65.00	0	171	0	3.00	
4.00	PHYSICAL THERAPY	66.00	0	2,055	0	4.00	
	TOTALS		0	7,628			
<b>C - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	4,558	3,710	0	1.00	
	TOTALS		4,558	3,710			
<b>D - NURSING ADMIN RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	73,177	0	0	1.00	
	TOTALS		73,177	0			
<b>E - INSURANCE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,412	12	1.00	
	TOTALS		0	13,412			
<b>F - PURCHASED SERVICES RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	287,078	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
	TOTALS		0	287,078			
500.00	Grand Total: Decreases		77,735	524,138		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	38,462	51,538	0	51,538	0	2.00
3.00	Buildings and Fixtures	284,587	6,829	0	6,829	286,337	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	177,595	25,449	0	25,449	177,595	5.00
6.00	Movable Equipment	1,284,232	158,201	0	158,201	867,771	6.00
7.00	HIT designated Assets	603,721	98,827	0	98,827	124,704	7.00
8.00	Subtotal (sum of lines 1-7)	2,388,597	340,844	0	340,844	1,456,407	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,388,597	340,844	0	340,844	1,456,407	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0				1.00
2.00	Land Improvements	90,000	0				2.00
3.00	Buildings and Fixtures	5,079	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	25,449	0				5.00
6.00	Movable Equipment	574,662	0				6.00
7.00	HIT designated Assets	577,844	0				7.00
8.00	Subtotal (sum of lines 1-7)	1,273,034	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	1,273,034	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	218,109	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	27,237	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	245,346	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	218,109				1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	27,237				1.01
3.00	Total (sum of lines 1-2)	0	245,346				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	95,079	0	95,079	0.074687	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	1,177,955	0	1,177,955	0.925313	0	1.01
3.00	Total (sum of lines 1-2)	1,273,034	0	1,273,034	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	218,109	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	27,237	0	1.01
3.00	Total (sum of lines 1-2)	0	0	0	245,346	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	13,412	0	0	231,521	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	27,237	1.01
3.00	Total (sum of lines 1-2)	0	13,412	0	0	258,758	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153039

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

Worksheet A-8

Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-24,134				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	412,876				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-59		ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

Provider CCN: 153039

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

Worksheet A-8

Date/Time Prepared:  
 5/31/2013 12:08 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 HRSC GENERAL ACCT MISCELLANEOUS REVE	B	-32	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 HRSC REPLAY OTHER RE REPLAY AFTER CA	B	-14,088	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 HRSC REPLAY OTHER RE OTHER OPERATING	B	-61,000	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 HRSC OTHER OPER. REV MISC REVENUE	B	-7,774	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 HRSC OTHER OPER. REV OTHER OPERATING	B	-14,547	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 HRSC DIETARY NON-FOO SALES	B	-1,277	DIETARY	10.00	0	33.05
33.06 HRSC MEDREC SALES MISC REVENUE	B	-1,462	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07 HRSC REPLAY OTHER RE REPLAY DME REVE	B	-5,911	PHYSICAL THERAPY	66.00	0	33.07
33.08 HRSC REPLAY OTHER RE PHYS OFF & OTH	B	-25,849	PHYSICIANS OFFICE	93.04	0	33.08
33.09 CHARITABLE DONATIONS	A	-1,377	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 ADVERTISING & PROMOTION	A	-28,308	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 ADVERTISING & PROMOTION	A	-5,776	PHYSICAL THERAPY	66.00	0	33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		221,282				50.00

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

Provider CCN: 153039

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

Worksheet A-8-1

Date/Time Prepared:  
5/31/2013 12:08 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	722,966	191,496 1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	1,300	6,788 2.00
3.00	57.00	CT SCAN	CT SCAN	912	4,761 3.00
4.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	MRI	141	813 4.00
4.01	60.00	LABORATORY	LAB	15,164	118,238 4.01
4.02	65.00	RESPIRATORY THERAPY	RT	2,256	7,326 4.02
4.03	66.00	PHYSICAL THERAPY	PT	3,189	2,889 4.03
4.04	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	MED SUPPLIES	1,984	2,725 4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			747,912	335,036 5.00

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

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

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

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

6.00	G	COMMUNITY HOWAR	60.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC SERVICES		0.00	100.00

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

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

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

Provider CCN: 153039

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

Worksheet A-8-1

Date/Time Prepared:  
5/31/2013 12:08 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	531,470	0		1.00
2.00	-5,488	0		2.00
3.00	-3,849	0		3.00
4.00	-672	0		4.00
4.01	-103,074	0		4.01
4.02	-5,070	0		4.02
4.03	300	0		4.03
4.04	-741	0		4.04
5.00	412,876			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

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

Worksheet A-8-2

Date/Time Prepared:  
5/31/2013 12:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	93.03	SLEEP LAB	36,000	0	36,000	171,400	144	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			36,000	0	36,000		144	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	93.03	SLEEP LAB	11,866	593	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			11,866	593	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	93.03	SLEEP LAB	0	11,866	24,134	24,134	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	11,866	24,134	24,134	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

Period:  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	BLDG & FIXT			
	0	1.00	1.01	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	231,521	231,521			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT	27,237	0	27,237		1.01
4.00 00400	EMPLOYEE BENEFITS	1,060,082	799	0	1,060,881	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,490,355	18,284	0	152,137	5.00
7.00 00700	OPERATION OF PLANT	1,785,156	90,242	0	52,846	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	37,535	2,916	0	0	8.00
9.00 00900	HOUSEKEEPING	123,750	1,837	0	11,452	9.00
10.00 01000	DIETARY	349,316	23,642	0	28,215	10.00
11.00 01100	CAFETERIA	8,268	0	0	665	11.00
13.00 01300	NURSING ADMINISTRATION	73,177	1,334	0	10,681	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	258,738	1,420	0	32,659	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,389,405	42,887	0	166,940	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,121	276	0	684	54.00
54.02 05401	IMAGING CENTER	0	0	0	0	54.02
57.00 05700	CT SCAN	5,673	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	955	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	134,868	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	294,891	389	0	37,241	65.00
66.00 06600	PHYSICAL THERAPY	3,829,991	30,797	27,237	454,960	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	262,062	4,413	0	6,061	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	579,670	2,839	0	37,900	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	91.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.02 04041	NEUROPSYCH OFFICE	98,463	1,878	0	12,660	93.02
93.03 04042	SLEEP LAB	453,861	2,247	0	55,780	93.03
93.04 04043	PHYSICIANS OFFICE	-25,517	5,321	0	0	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,487,578	231,521	27,237	1,060,881	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,487,578	231,521	27,237	1,060,881	202.00
<b>Summary Table</b>						
	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT					1.01
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,660,776				5.00
7.00 00700	OPERATION OF PLANT	473,000	2,401,244			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	9,923	57,305	107,679		8.00
9.00 00900	HOUSEKEEPING	33,616	36,105	0	206,760	9.00
10.00 01000	DIETARY	98,408	464,580	0	41,622	10.00
11.00 01100	CAFETERIA	2,191	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	20,898	26,222	0	2,349	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	71,828	27,895	0	2,499	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	392,293	842,762	107,679	75,504	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,681	5,420	0	486	54.00
54.02 05401	IMAGING CENTER	0	0	0	0	54.02
57.00 05700	CT SCAN	1,392	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	234	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	33,083	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	81,568	7,651	0	685	65.00
66.00 06600	PHYSICAL THERAPY	1,065,335	605,173	0	54,218	66.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	66,853	86,715	0	7,769	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	152,187	55,791	0	4,998	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	27,719	36,902	0	3,306	0	93.02
93.03	04042 SLEEP LAB	125,567	44,155	0	3,956	0	93.03
93.04	04043 PHYSICIANS OFFICE	0	104,568	0	9,368	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,660,776	2,401,244	107,679	206,760	1,005,783	118.00
NONREIMBURSABLE COST CENTERS							
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)	2,660,776	2,401,244	107,679	206,760	1,005,783	202.00
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT						1.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	11,124					11.00
13.00	01300 NURSING ADMINISTRATION	183	134,844				13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	787	0	395,826			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,852	80,907	118,748	4,225,760	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	8	6,742	0	36,418	0	54.00
54.02	05401 IMAGING CENTER	0	0	0	0	0	54.02
57.00	05700 CT SCAN	0	0	0	7,065	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,189	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	6,742	0	174,693	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	497	13,484	19,791	456,197	0	65.00
66.00	06600 PHYSICAL THERAPY	5,276	20,227	217,704	6,310,918	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	109	0	0	433,982	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	365	0	0	833,750	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	155	6,742	39,583	227,408	0	93.02
93.03	04042 SLEEP LAB	892	0	0	686,458	0	93.03
93.04	04043 PHYSICIANS OFFICE	0	0	0	93,740	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,124	134,844	395,826	13,487,578	0	118.00
NONREIMBURSABLE COST CENTERS							
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)	11,124	134,844	395,826	13,487,578	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	1.01
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.02	05401	IMAGING CENTER	54.02
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.02	04041	NEUROPSYCH OFFICE	93.02
93.03	04042	SLEEP LAB	93.03
93.04	04043	PHYSICIANS OFFICE	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910	CORF	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	BLDG & FIXT			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT					1.01
4.00 00400	EMPLOYEE BENEFITS	0	799	0	799	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	18,284	0	18,284	5.00
7.00 00700	OPERATION OF PLANT	0	90,242	0	90,242	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,916	0	2,916	8.00
9.00 00900	HOUSEKEEPING	0	1,837	0	1,837	9.00
10.00 01000	DIETARY	0	23,642	0	23,642	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,334	0	1,334	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	1,420	0	1,420	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	42,887	0	42,887	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	276	0	276	54.00
54.02 05401	IMAGING CENTER	0	0	0	0	54.02
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	389	0	389	65.00
66.00 06600	PHYSICAL THERAPY	0	30,797	27,237	58,034	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,413	0	4,413	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	2,839	0	2,839	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	91.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.02 04041	NEUROPSYCH OFFICE	0	1,878	0	1,878	93.02
93.03 04042	SLEEP LAB	0	2,247	0	2,247	93.03
93.04 04043	PHYSICIANS OFFICE	0	5,321	0	5,321	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	231,521	27,237	258,758	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	231,521	27,237	258,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500	18,399					5.00
7.00	00700	3,270	93,552				7.00
8.00	00800	69	2,233	5,218			8.00
9.00	00900	232	1,407	0	3,485		9.00
10.00	01000	680	18,100	0	702	43,145	10.00
11.00	01100	15	0	0	0	0	11.00
13.00	01300	144	1,022	0	40	0	13.00
16.00	01600	497	1,087	0	42	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	2,712	32,833	5,218	1,271	43,145	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	32	211	0	8	0	54.00
54.02	05401	0	0	0	0	0	54.02
57.00	05700	10	0	0	0	0	57.00
58.00	05800	2	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	229	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	564	298	0	12	0	65.00
66.00	06600	7,369	23,577	0	914	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	462	3,378	0	131	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,052	2,174	0	84	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	192	1,438	0	56	0	93.02
93.03	04042	868	1,720	0	67	0	93.03
93.04	04043	0	4,074	0	158	0	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		18,399	93,552	5,218	3,485	43,145	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		18,399	93,552	5,218	3,485	43,145	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	16	2,548				13.00
16.00	01600	0		3,072			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4	1,530	922	130,648	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	127	0	655	0	54.00
54.02	05401	0	0	0	0	0	54.02
57.00	05700	0	0	0	10	0	57.00
58.00	05800	0	0	0	2	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	127	0	356	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1	255	154	1,701	0	65.00
66.00	06600	8	382	1,689	92,312	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	8,389	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1	0	0	6,179	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	0	127	307	4,008	0	93.02
93.03	04042	1	0	0	4,945	0	93.03
93.04	04043	0	0	0	9,553	0	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		16	2,548	3,072	258,758	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		16	2,548	3,072	258,758	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	1.01
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.02	05401	IMAGING CENTER	54.02
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100	EMERGENCY	91.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.02	04041	NEUROPSYCH OFFICE	93.02
93.03	04042	SLEEP LAB	93.03
93.04	04043	PHYSICIANS OFFICE	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910	CORF	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1

Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (DIRECT ALLOCATION)				
	1.00	1.01				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	57,082				1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT	0	100			1.01
4.00 00400	EMPLOYEE BENEFITS	197	0	7,268,012		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,508	0	1,042,277	-2,660,776	5.00
7.00 00700	OPERATION OF PLANT	22,249	0	362,046	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	719	0	0	0	8.00
9.00 00900	HOUSEKEEPING	453	0	78,457	0	9.00
10.00 01000	DIETARY	5,829	0	193,301	0	10.00
11.00 01100	CAFETERIA	0	0	4,558	0	11.00
13.00 01300	NURSING ADMINISTRATION	329	0	73,177	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	350	0	223,742	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	10,574	0	1,143,690	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	68	0	4,687	0	54.00
54.02 05401	IMAGING CENTER	0	0	0	0	54.02
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	96	0	255,135	0	65.00
66.00 06600	PHYSICAL THERAPY	7,593	100	3,116,897	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	41,520	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	700	0	259,649	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	91.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.02 04041	NEUROPSYCH OFFICE	463	0	86,730	0	93.02
93.03 04042	SLEEP LAB	554	0	382,146	0	93.03
93.04 04043	PHYSICIANS OFFICE	1,312	0	0	20,196	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,082	100	7,268,012	-2,640,580	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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)	231,521	27,237	1,060,881	2,660,776	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.055937	272.370000	0.145966	0.245301	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			799	18,399	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000110	0.001696	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1

Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE' S)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	30,128					7.00
8.00	00800	719	68,050				8.00
9.00	00900	453	0	28,956			9.00
10.00	01000	5,829	0	5,829	18,051		10.00
11.00	01100	0	0	0	0	9,381	11.00
13.00	01300	329	0	329	0	154	13.00
16.00	01600	350	0	350	0	664	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	10,574	68,050	10,574	18,051	2,405	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	68	0	68	0	7	54.00
54.02	05401	0	0	0	0	0	54.02
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	96	0	96	0	419	65.00
66.00	06600	7,593	0	7,593	0	4,449	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	1,088	0	1,088	0	92	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	700	0	700	0	308	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	463	0	463	0	131	93.02
93.03	04042	554	0	554	0	752	93.03
93.04	04043	1,312	0	1,312	0	0	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		30,128	68,050	28,956	18,051	9,381	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
200.00							200.00
201.00							201.00
202.00		2,401,244	107,679	206,760	1,005,783	11,124	202.00
203.00		79.701407	1.582351	7.140489	55.718963	1.185801	203.00
204.00		93,552	5,218	3,485	43,145	16	204.00
205.00		3.105151	0.076679	0.120355	2.390172	0.001706	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

Worksheet B-1  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NURSING HRS) 13.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
1.01	00101			1.01
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300	100		13.00
16.00	01600	0	100	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	60	30	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400	5	0	54.00
54.02	05401	0	0	54.02
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
59.00	05900	0	0	59.00
60.00	06000	5	0	60.00
60.01	06001	0	0	60.01
65.00	06500	10	5	65.00
66.00	06600	15	55	66.00
69.00	06900	0	0	69.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100	0	0	91.00
93.00	04040	0	0	93.00
93.02	04041	5	10	93.02
93.03	04042	0	0	93.03
93.04	04043	0	0	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		100	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
200.00				200.00
201.00				201.00
202.00		134,844	395,826	202.00
203.00		1,348.440000	3,958.260000	203.00
204.00		2,548	3,072	204.00
205.00		25.480000	30.720000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

Title XVIII

Hospital

PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges	
			Total Costs	RCE Disallowance	Total Costs	Inpatient	
			1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	4,225,760		4,225,760	0	4,225,760	5,076,143	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00 05400 RADIOLOGY-DIAGNOSTIC	36,418		36,418	0	36,418	101,946	54.00
54.02 05401 IMAGING CENTER	0		0	0	0	0	54.02
57.00 05700 CT SCAN	7,065		7,065	0	7,065	29,927	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,189		1,189	0	1,189	40,216	58.00
59.00 05900 CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00 06000 LABORATORY	174,693		174,693	0	174,693	1,255,976	60.00
60.01 06001 BLOOD LABORATORY	0		0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	456,197	0	456,197	0	456,197	608,038	65.00
66.00 06600 PHYSICAL THERAPY	6,310,918	0	6,310,918	0	6,310,918	3,282,892	66.00
69.00 06900 ELECTROCARDIOLOGY	0		0	0	0	129,519	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	433,982		433,982	0	433,982	227,574	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	833,750		833,750	0	833,750	963,229	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100 EMERGENCY	0		0	0	0	0	91.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	0	93.00
93.02 04041 NEUROPSYCH OFFICE	227,408		227,408	0	227,408	245,629	93.02
93.03 04042 SLEEP LAB	686,458		686,458	24,134	710,592	0	93.03
93.04 04043 PHYSICIANS OFFICE	93,740		93,740	0	93,740	0	93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0		0		0	0	99.10
200.00 Subtotal (see instructions)	13,487,578	0	13,487,578	24,134	13,511,712	11,961,089	200.00
201.00 Less Observation Beds	0		0		0	0	201.00
202.00 Total (see instructions)	13,487,578	0	13,487,578	24,134	13,511,712	11,961,089	202.00
<b>Charges</b>							
Cost Center Description	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
	7.00	8.00	9.00	10.00	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS		5,076,143					30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	101,946	0.357228	0.000000	0.357228		54.00
54.02 05401 IMAGING CENTER	0	0	0.000000	0.000000	0.000000		54.02
57.00 05700 CT SCAN	0	29,927	0.236074	0.000000	0.236074		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	40,216	0.029565	0.000000	0.029565		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00
60.00 06000 LABORATORY	5,324	1,261,300	0.138502	0.000000	0.138502		60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00 06500 RESPIRATORY THERAPY	18,954	626,992	0.727596	0.000000	0.727596		65.00
66.00 06600 PHYSICAL THERAPY	10,375,225	13,658,117	0.462064	0.000000	0.462064		66.00
69.00 06900 ELECTROCARDIOLOGY	0	129,519	0.000000	0.000000	0.000000		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,928	229,502	1.890973	0.000000	1.890973		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	97	963,326	0.865491	0.000000	0.865491		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00 09100 EMERGENCY	0	0	0.000000	0.000000	0.000000		91.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0.000000		93.00
93.02 04041 NEUROPSYCH OFFICE	112,432	358,061	0.635110	0.000000	0.635110		93.02
93.03 04042 SLEEP LAB	3,895,797	3,895,797	0.176205	0.000000	0.182400		93.03
93.04 04043 PHYSICIANS OFFICE	0	0	0.000000	0.000000	0.000000		93.04
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0					99.10
200.00 Subtotal (see instructions)	14,409,757	26,370,846					200.00
201.00 Less Observation Beds							201.00
202.00 Total (see instructions)	14,409,757	26,370,846					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

			Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Disallowance	Total Costs	Inpatient		
			1.00	2.00	3.00	4.00	5.00	6.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	4,225,760		4,225,760	0	0	5,076,143	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADIOLOGY-DIAGNOSTIC	36,418		36,418	0	0	101,946	54.00
54.02	05401 IMAGING CENTER	0		0	0	0	0	54.02
57.00	05700 CT SCAN	7,065		7,065	0	0	29,927	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,189		1,189	0	0	40,216	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000 LABORATORY	174,693		174,693	0	0	1,255,976	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	456,197	0	456,197	0	0	608,038	65.00
66.00	06600 PHYSICAL THERAPY	6,310,918	0	6,310,918	0	0	3,282,892	66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	129,519	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	433,982		433,982	0	0	227,574	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	833,750		833,750	0	0	963,229	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0		0	0	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	227,408		227,408	0	0	245,629	93.02
93.03	04042 SLEEP LAB	686,458		686,458	0	0	0	93.03
93.04	04043 PHYSICIANS OFFICE	93,740		93,740	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS								
99.10	09910 CORF	0		0	0	0	0	99.10
200.00	Subtotal (see instructions)	13,487,578	0	13,487,578	0	0	11,961,089	200.00
201.00	Less Observation Beds	0		0	0	0	0	201.00
202.00	Total (see instructions)	13,487,578	0	13,487,578	0	0	11,961,089	202.00
Charges								
Cost Center Description	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00	9.00	10.00	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS		5,076,143					30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	101,946	0.357228	0.000000	0.000000		54.00
54.02	05401 IMAGING CENTER	0	0	0.000000	0.000000	0.000000		54.02
57.00	05700 CT SCAN	0	29,927	0.236074	0.000000	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	40,216	0.029565	0.000000	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00
60.00	06000 LABORATORY	5,324	1,261,300	0.138502	0.000000	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	18,954	626,992	0.727596	0.000000	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	10,375,225	13,658,117	0.462064	0.000000	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0	129,519	0.000000	0.000000	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,928	229,502	1.890973	0.000000	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	97	963,326	0.865491	0.000000	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0.000000		91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0.000000		93.00
93.02	04041 NEUROPSYCH OFFICE	112,432	358,061	0.635110	0.000000	0.000000		93.02
93.03	04042 SLEEP LAB	3,895,797	3,895,797	0.176205	0.000000	0.000000		93.03
93.04	04043 PHYSICIANS OFFICE	0	0	0.000000	0.000000	0.000000		93.04
OTHER REIMBURSABLE COST CENTERS								
99.10	09910 CORF	0	0					99.10
200.00	Subtotal (see instructions)	14,409,757	26,370,846					200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	14,409,757	26,370,846					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153039		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/31/2013 12:08 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	130,648	0	130,648	6,017	21.71	30.00
200.00	Total (Lines 30-199)	130,648		130,648	6,017		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	5,199	112,870				
200.00	Total (Lines 30-199)	5,199	112,870				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/31/2013 12:08 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	655	101,946	0.006425	98,029	630	54.00
54.02	05401 IMAGING CENTER	0	0	0.000000	0	0	54.02
57.00	05700 CT SCAN	10	29,927	0.000334	22,173	7	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2	40,216	0.000050	13,381	1	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	356	1,261,300	0.000282	1,109,431	313	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	1,701	626,992	0.002713	539,125	1,463	65.00
66.00	06600 PHYSICAL THERAPY	92,312	13,658,117	0.006759	2,784,862	18,823	66.00
69.00	06900 ELECTROCARDIOLOGY	0	129,519	0.000000	107,112	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,389	229,502	0.036553	196,372	7,178	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	6,179	963,326	0.006414	827,659	5,309	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	0	0	0.000000	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	4,008	358,061	0.011194	0	0	93.02
93.03	04042 SLEEP LAB	4,945	3,895,797	0.001269	0	0	93.03
93.04	04043 PHYSICIANS OFFICE	9,553	0	0.000000	0	0	93.04
200.00	Total (lines 50-199)	128,110	21,294,703		5,698,144	33,724	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153039		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/31/2013 12:08 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,017	0.00	5,199	0		30.00
200.00		Total (lines 30-199)	6,017		5,199	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 12:08 pm
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Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	05401	IMAGING CENTER	0	0	0	0	0	54.02
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02	04041	NEUROPSYCH OFFICE	0	0	0	0	0	93.02
93.03	04042	SLEEP LAB	0	0	0	0	0	93.03
93.04	04043	PHYSICIANS OFFICE	0	0	0	0	0	93.04
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: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 12:08 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,946	0.000000	0.000000	98,029	54.00
54.02	05401	IMAGING CENTER	0	0	0.000000	0.000000	0	54.02
57.00	05700	CT SCAN	0	29,927	0.000000	0.000000	22,173	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	40,216	0.000000	0.000000	13,381	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	1,261,300	0.000000	0.000000	1,109,431	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	626,992	0.000000	0.000000	539,125	65.00
66.00	06600	PHYSICAL THERAPY	0	13,658,117	0.000000	0.000000	2,784,862	66.00
69.00	06900	ELECTROCARDIOLOGY	0	129,519	0.000000	0.000000	107,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229,502	0.000000	0.000000	196,372	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	963,326	0.000000	0.000000	827,659	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.02	04041	NEUROPSYCH OFFICE	0	358,061	0.000000	0.000000	0	93.02
93.03	04042	SLEEP LAB	0	3,895,797	0.000000	0.000000	0	93.03
93.04	04043	PHYSICIANS OFFICE	0	0	0.000000	0.000000	0	93.04
200.00		Total (lines 50-199)	0	21,294,703			5,698,144	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 12:08 pm
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.02	05401 IMAGING CENTER	0	0	0	54.02
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	4,121	0	65.00
66.00	06600 PHYSICAL THERAPY	0	9,471	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	0	0	0	93.02
93.03	04042 SLEEP LAB	0	1,246,267	0	93.03
93.04	04043 PHYSICIANS OFFICE	0	0	0	93.04
200.00	Total (lines 50-199)	0	1,259,859	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 12:08 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.357228	0	0	0	54.00
54.02 05401	IMAGING CENTER	0.000000	0	0	0	54.02
57.00 05700	CT SCAN	0.236074	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0.029565	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 06000	LABORATORY	0.138502	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0.727596	4,121	0	2,998	65.00
66.00 06600	PHYSICAL THERAPY	0.462064	9,471	0	4,376	66.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.890973	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	0.865491	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0.000000	0	0	0	91.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
93.02 04041	NEUROPSYCH OFFICE	0.635110	0	0	0	93.02
93.03 04042	SLEEP LAB	0.176205	1,246,267	0	219,598	93.03
93.04 04043	PHYSICIANS OFFICE	0.000000	0	0	0	93.04
200.00	Subtotal (see instructions)		1,259,859	0	226,972	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		1,259,859	0	226,972	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 12:08 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.02 05401	IMAGING CENTER	0	0	54.02
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
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100	EMERGENCY	0	0	91.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.02 04041	NEUROPSYCH OFFICE	0	0	93.02
93.03 04042	SLEEP LAB	0	0	93.03
93.04 04043	PHYSICIANS OFFICE	0	0	93.04
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/31/2013 12:08 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,017	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,017	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)		6,017	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,199	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,225,760	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,225,760	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,076,143	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,076,143	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.832475	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)		843.63	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,225,760	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		702.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,651,258	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)		3,651,258	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/31/2013 12:08 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,961,021 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,612,279 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)					112,870 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					33,724 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					146,594 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,465,685 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)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 12:08 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	130,648	4,225,760	0.030917	0	0	90.00
91.00	Nursing School cost	0	4,225,760	0.000000	0	0	91.00
92.00	Allied health cost	0	4,225,760	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,225,760	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/31/2013 12:08 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		4,414,961		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357228	98,029	35,019	54.00
54.02	05401 IMAGING CENTER	0.000000	0	0	54.02
57.00	05700 CT SCAN	0.236074	22,173	5,234	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.029565	13,381	396	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.138502	1,109,431	153,658	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.727596	539,125	392,265	65.00
66.00	06600 PHYSICAL THERAPY	0.462064	2,784,862	1,286,784	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	107,112	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.890973	196,372	371,334	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.865491	827,659	716,331	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	0.635110	0	0	93.02
93.03	04042 SLEEP LAB	0.182400	0	0	93.03
93.04	04043 PHYSICIANS OFFICE	0.000000	0	0	93.04
200.00	Total (sum of lines 50-94 and 96-98)		5,698,144	2,961,021	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)		5,698,144		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/31/2013 12:08 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		76,424		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357228	3,188	1,139	54.00
54.02	05401 IMAGING CENTER	0.000000	0	0	54.02
57.00	05700 CT SCAN	0.236074	2,831	668	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.029565	7,609	225	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.138502	13,345	1,848	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.727596	5,693	4,142	65.00
66.00	06600 PHYSICAL THERAPY	0.462064	54,776	25,310	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	596	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.890973	1,663	3,145	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.865491	16,605	14,371	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000	0	0	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.02	04041 NEUROPSYCH OFFICE	0.635110	3,447	2,189	93.02
93.03	04042 SLEEP LAB	0.176205	0	0	93.03
93.04	04043 PHYSICIANS OFFICE	0.000000	0	0	93.04
200.00	Total (sum of lines 50-94 and 96-98)		109,753	53,037	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)		109,753		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/31/2013 12:08 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			226,972 2.00
3.00	PPS payments			251,576 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)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 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)			251,576 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			85,046 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)			166,530 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)			166,530 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			166,530 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			38,714 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			27,100 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			38,151 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			193,630 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			193,630 40.00
41.00	Interim payments			166,529 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)			27,101 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153039

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/31/2013 12:08 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		6,327,867		166,529	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,327,867		166,529	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		26,299		27,101	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		6,354,166		193,630	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/31/2013 12:08 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			6,382,574 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0242 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			137,538 3.00
4.00	Outlier Payments			7,751 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			16.439891 10.00
11.00	Medical Education Adjustment Factor $\{(1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1\}$ .			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			6,527,863 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,527,863 17.00
18.00	Primary payer payments			4,619 18.00
19.00	Subtotal (line 17 less line 18).			6,523,244 19.00
20.00	Deductibles			172,124 20.00
21.00	Subtotal (line 19 minus line 20)			6,351,120 21.00
22.00	Coinsurance			6,358 22.00
23.00	Subtotal (line 21 minus line 22)			6,344,762 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			13,434 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			9,404 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,068 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,354,166 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,354,166 32.00
33.00	Interim payments			6,327,867 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			26,299 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			10,000 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			7,751 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 153039

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

Worksheet G

Date/Time Prepared:  
5/31/2013 12:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	789,166	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,110,317	0	0	0	4.00
5.00	Other receivable	12,207	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-813,260	0	0	0	6.00
7.00	Inventory	213,715	0	0	0	7.00
8.00	Prepaid expenses	55,073	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,367,218	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,146,498	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,146,498	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	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)	4,513,716	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	427,194	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	866,339	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,293,533	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,293,533	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	3,220,183				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)	3,220,183	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,513,716	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153039

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

Worksheet G-1

Date/Time Prepared:  
5/31/2013 12:08 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		1,742,254		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,477,929			2.00
3.00	Total (sum of line 1 and line 2)		3,220,183		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)		3,220,183		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)		3,220,183		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 153039

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/31/2013 12:08 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	5,076,143		5,076,143	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,076,143		5,076,143	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,076,143		5,076,143	17.00
18.00	Ancillary services	6,639,317	10,401,528	17,040,845	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
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)	245,629	4,008,229	4,253,858	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,961,089	14,409,757	26,370,846	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,266,296		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,266,296		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153039

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

Worksheet G-3

Date/Time Prepared:  
5/31/2013 12:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,370,846	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,485,117	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,885,729	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,266,296	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,619,433	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	4,674	24.00
24.01	OTHER OPERATING REVENUE	133,782	24.01
24.02	NONOPERATING ITEMS	1,049	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	139,505	25.00
26.00	Total (line 5 plus line 25)	1,758,938	26.00
27.00	BAD DEBT EXPENSE	281,009	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	281,009	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,477,929	29.00