

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 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/29/2012 7:46 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/29/2012 Time: 7:46 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HRHS SPECIALTY HOSPITAL for the cost reporting period beginning 01/01/2012 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	20,131	7,998	0	19,546
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 SKILLED NURSING FACILITY	0	0	0	0	0
8.00 NURSING FACILITY	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	20,131	7,998	0	19,546

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 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 7:45 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 829 N. DIXON ROAD		PO Box:						1.00			
2.00	City: KOKOMO		State: IN		Zip Code: 46901-		County: HOWARD		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		HRHS 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								N	N	N	7.00
8.00	Swing Beds - NF								N	N	N	8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC								N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC								N	N	N	16.00
17.00	Hospital-Based (CMHC) 1											17.00
17.10	Hospital-Based (CORF) 1								N	N	N	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		06/30/2012		20.00	
21.00	Type of Control (see instructions)								6		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid eligible days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			19	0	0	0	47	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	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.								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	
								Beginning:	Ending:			
								1.00	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 7:45 pm		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

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

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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				
Long Term Care Hospital PPS						
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
		V		XIX		
		1.00		2.00		
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	Y	109.00
		1.00		2.00		3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

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			1.00	2.00	3.00
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
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	29,754	0	0	118.01
			1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		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		141.00
142.00	Street: 3500 S. LAFOUNTAIN	PO Box:			142.00
143.00	City: KOKOMO	State:	Zip Code: 46902		143.00
			1.00	2.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 7:45 pm
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		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	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
					1.00		
Multi-campus							
165.00	Is this hospital part of a Multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	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
					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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/29/2012 7:45 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/05/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	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			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet S-2
Part II
Date/Time Prepared:
11/29/2012 7:45 pm

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

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/05/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	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		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	30	5,460	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		30	5,460	0.00	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	5,460	0.00	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	99.10				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		30			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,712	19	3,146		1.00
2.00 HMO		31	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	47			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	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)	0	2,712	19	3,146		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	2,712	19	3,146		14.00
15.00 CAH visits	0	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		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	270	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	145.39	0.00	0	270	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	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	145.39	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2	323		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	2	323		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				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
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 06/30/2012

Worksheet A
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		96,261	96,261	6,927	103,188	1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT		17,124	17,124	0	17,124	1.01
4.00 00400	EMPLOYEE BENEFITS	-47,323	552,176	504,853	-2,816	502,037	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	538,511	524,815	1,063,326	-6,927	1,056,399	5.00
7.00 00700	OPERATION OF PLANT	172,806	668,201	841,007	0	841,007	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	21,395	21,395	0	21,395	8.00
9.00 00900	HOUSEKEEPING	38,031	20,166	58,197	-588	57,609	9.00
10.00 01000	DIETARY	96,653	69,728	166,381	-2,620	163,761	10.00
11.00 01100	CAFETERIA	0	0	0	2,620	2,620	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	55,359	55,359	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	113,616	14,591	128,207	0	128,207	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	602,481	298,094	900,575	-214,745	685,830	30.00
ANCILLARY SERVICE COST CENTERS							
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,833	3,000	4,833	11,202	16,035	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	1,110	1,110	107,141	108,251	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	126,025	37,629	163,654	-16,457	147,197	65.00
66.00 06600	PHYSICAL THERAPY	1,530,214	305,460	1,835,674	-16,047	1,819,627	66.00
69.00 06900	ELECTROCARDIOLOGY	0	30,000	30,000	0	30,000	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,179	3,892	25,071	92,649	117,720	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	129,733	180,537	310,270	2,157	312,427	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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	42,188	5,234	47,422	0	47,422	93.02
93.03 04042	SLEEP LAB	187,059	63,720	250,779	-17,855	232,924	93.03
93.04 04043	PHYSICIANS OFFICE	0	-9	-9	0	-9	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)	3,553,006	2,913,124	6,466,130	0	6,466,130	118.00
NONREIMBURSABLE COST CENTERS							
200.00	TOTAL (SUM OF LINES 118-199)	3,553,006	2,913,124	6,466,130	0	6,466,130	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			
	00100			
1.01	00101			
	00101			
4.00	00400			
	00400			
5.00	00500			
	00500			
7.00	00700			
	00700			
8.00	00800			
	00800			
9.00	00900			
	00900			
10.00	01000			
	01000			
11.00	01100			
	01100			
13.00	01300			
	01300			
16.00	01600			
	01600			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000			
	03000			
ANCILLARY SERVICE COST CENTERS				
54.00	05400			
	05400			
54.02	05401			
	05401			
57.00	05700			
	05700			
58.00	05800			
	05800			
59.00	05900			
	05900			
60.00	06000			
	06000			
60.01	06001			
	06001			
65.00	06500			
	06500			
66.00	06600			
	06600			
69.00	06900			
	06900			
71.00	07100			
	07100			
72.00	07200			
	07200			
73.00	07300			
	07300			
OUTPATIENT SERVICE COST CENTERS				
88.00	08800			
	08800			
89.00	08900			
	08900			
91.00	09100			
	09100			
93.00	04040			
	04040			
93.02	04041			
	04041			
93.03	04042			
	04042			
93.04	04043			
	04043			
OTHER REIMBURSABLE COST CENTERS				
99.10	09910			
	09910			
SPECIAL PURPOSE COST CENTERS				
118.00				
NONREIMBURSABLE COST CENTERS				
200.00				

RECLASSIFICATIONS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-6

Date/Time Prepared:
11/29/2012 7:45 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		90,180	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	90,180	
B - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00		3,417	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
	TOTALS		0	3,417	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	1,522	1,098	1.00
	TOTALS		1,522	1,098	
D - NURSING ADMIN RECLASS					
1.00	NURSING ADMINISTRATION	13.00	55,359	0	1.00
	TOTALS		55,359	0	
E - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,927	1.00
	TOTALS		0	6,927	
F - MEDICAL PURCHASED SERVICES RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,151	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,314	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	737	3.00
4.00	LABORATORY	60.00	0	107,141	4.00
5.00	RESPIRATORY THERAPY	65.00	0	6,638	5.00
6.00	PHYSICAL THERAPY	66.00	0	2,618	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,469	7.00
	TOTALS		0	130,068	
500.00	Grand Total: Increases		56,881	231,690	500.00

RECLASSIFICATIONS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-6

Date/Time Prepared:
11/29/2012 7:45 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS	4.00		1,582	0		1.00
2.00		9.00		588	0		2.00
3.00		30.00		29,300	0		3.00
4.00		65.00		22,985	0		4.00
5.00		66.00		16,610	0		5.00
6.00		73.00		1,260	0		6.00
7.00		93.03		17,855	0		7.00
	TOTALS		0	90,180			
B - PHARMACY RECLASS							
1.00	EMPLOYEE BENEFITS	4.00		1,234	0		1.00
2.00		30.00		18	0		2.00
3.00		65.00		110	0		3.00
4.00		66.00		2,055	0		4.00
	TOTALS		0	3,417			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	1,522	1,098	0		1.00
	TOTALS		1,522	1,098			
D - NURSING ADMIN RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	55,359	0	0		1.00
	TOTALS		55,359	0			
E - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,927	12		1.00
	TOTALS		0	6,927			
F - MEDICAL PURCHASED SERVICES RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	130,068	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	130,068			
500.00	Grand Total: Decreases		56,881	231,690			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 7:45 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	38,462	0	0	0	0	2.00
3.00	Buildings and Fixtures	284,587	3,107	0	3,107	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	177,595	28,043	0	28,043	0	5.00
6.00	Movable Equipment	1,284,232	26,863	0	26,863	0	6.00
7.00	HIT designated Assets	603,721	73,012	0	73,012	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,388,597	131,025	0	131,025	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,388,597	131,025	0	131,025	0	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	96,261	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	17,124	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	113,385	0	0	0	0	3.00
COMPUTATION OF RATIOS					ALLOCATION OF OTHER CAPITAL		
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 7:45 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0		1.00		
2.00	Land Improvements	38,462	0		2.00		
3.00	Buildings and Fixtures	287,694	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	205,638	0		5.00		
6.00	Movable Equipment	1,311,095	0		6.00		
7.00	HIT designated Assets	676,733	0		7.00		
8.00	Subtotal (sum of lines 1-7)	2,519,622	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	2,519,622	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	96,261		1.00		
1.01	CAP REL COSTS-BLDG & FIXT	0	17,124		1.01		
3.00	Total (sum of lines 1-2)	0	113,385		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	96,261	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	17,124	0	1.01
3.00	Total (sum of lines 1-2)	0	0	0	113,385	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	6,927	0	0	103,188	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	17,124	1.01
3.00	Total (sum of lines 1-2)	0	6,927	0	0	120,312	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.01	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	2.00
3.00 Investment income - other (chapter 2)			0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	7.00
8.00 Television and radio service (chapter 21)			0		0.00	8.00
9.00 Parking lot (chapter 21)			0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-12,067				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	122,877				12.00
13.00 Laundry and linen service			0		0.00	13.00
14.00 Cafeteria-employees and guests			0		0.00	14.00
15.00 Rental of quarters to employee and others			0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	16.00
17.00 Sale of drugs to other than patients			0		0.00	17.00
18.00 Sale of medical records and abstracts			0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	19.00
20.00 Vending machines	B	-46		ADMINISTRATIVE & GENERAL	5.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.01	26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		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	32.00
33.00 HRSC GENERAL ACCT MISCELLANEOUS REVE	B	-32		ADMINISTRATIVE & GENERAL	5.00	33.00
34.00 HRSC REPLAY OTHER RE REPLAY AFTER CA	B	-7,660		ADMINISTRATIVE & GENERAL	5.00	34.00
35.00 HRSC REPLAY OTHER RE OTHER OPERATING	B	-17,144		ADMINISTRATIVE & GENERAL	5.00	35.00
36.00 HRSC OTHER OPER. REV MISC REVENUE	B	-2,499		ADMINISTRATIVE & GENERAL	5.00	36.00
37.00 HRSC OTHER OPER. REV OTHER OPERATING	B	-10,410		ADMINISTRATIVE & GENERAL	5.00	37.00
38.00 HRSC DIETARY NON-FOO SALES	B	-453		DIETARY	10.00	38.00
39.00 HRSC MEDREC SALES MISC REVENUE	B	-1,066		MEDICAL RECORDS & LIBRARY	16.00	39.00
40.00 HRSC OCCUPATIONAL TH MISCELLANEOUS R	B	-1,785		PHYSICAL THERAPY	66.00	40.00
41.00 HRSC REPLAY OTHER RE REPLAY DME REVE	B	-5,911		PHYSICAL THERAPY	66.00	41.00
42.00 HRSC REPLAY OTHER RE PHYS OFF & OTH	B	-5,188		PHYSICIANS OFFICE	93.04	42.00
43.00 CHARITABLE DONATIONS	A	-750		ADMINISTRATIVE & GENERAL	5.00	43.00
44.00 ADVERTISING & PROMOTION	A	-8,771		ADMINISTRATIVE & GENERAL	5.00	44.00
45.00 ADVERTISING & PROMOTION	A	-895		PHYSICAL THERAPY	66.00	45.00
45.01			0		0.00	45.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		48,200				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	HRSC GENERAL ACCT MISCELLANEOUS REVE	0	33.00
34.00	HRSC REPLAY OTHER RE REPLAY AFTER CA	0	34.00
35.00	HRSC REPLAY OTHER RE OTHER OPERATING	0	35.00
36.00	HRSC OTHER OPER. REV MISC REVENUE	0	36.00
37.00	HRSC OTHER OPER. REV OTHER OPERATING	0	37.00
38.00	HRSC DIETARY NON-FOO SALES	0	38.00
39.00	HRSC MEDREC SALES MISC REVENUE	0	39.00
40.00	HRSC OCCUPATIONAL TH MISCELLANEOUS R	0	40.00
41.00	HRSC REPLAY OTHER RE REPLAY DME REVE	0	41.00
42.00	HRSC REPLAY OTHER RE PHYS OFF & OTH	0	42.00
43.00	CHARITABLE DONATIONS	0	43.00
44.00	ADVERTISING & PROMOTION	0	44.00
45.00	ADVERTISING & PROMOTION	0	45.00
45.01		0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-8-1

Date/Time Prepared:
11/29/2012 7:45 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	CT SCAN	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	MRI	4.00
4.01	60.00	LABORATORY	LAB	4.01
4.02	65.00	RESPIRATORY THERAPY	RT	4.02
4.03	66.00	PHYSICAL THERAPY	PT	4.03
4.04	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	MED SUPPLIES	4.04
4.05	0.00			4.05
4.06	0.00			4.06
4.07	0.00			4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	G	HOWARD REGIONAL	60.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC SERVICES		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 06/30/2012

Worksheet A-8-1

Date/Time Prepared: 11/29/2012 7:45 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	338,914	95,748	243,166	0	1.00
2.00	575	6,151	-5,576	0	2.00
3.00	403	4,314	-3,911	0	3.00
4.00	85	737	-652	0	4.00
4.01	4,377	107,141	-102,764	0	4.01
4.02	977	6,638	-5,661	0	4.02
4.03	1,566	2,618	-1,052	0	4.03
4.04	1,796	2,469	-673	0	4.04
4.05	0	0	0	0	4.05
4.06	0	0	0	0	4.06
4.07	0	0	0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	348,693	225,816	122,877	5.00

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

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

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

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

6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:		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 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:45 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		93.03	SLEEP LAB	18,000	0	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				18,000	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:45 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	18,000	171,400	72	5,933	297	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	18,000		72	5,933	297	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:45 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	5,933	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	5,933	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:45 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	12,067	12,067	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	12,067	12,067	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

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	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	103,188	103,188			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT	17,124	0	17,124		1.01
4.00 00400	EMPLOYEE BENEFITS	502,037	356	0	502,393	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,252,253	8,547	0	75,144	1,335,944 5.00
7.00 00700	OPERATION OF PLANT	841,007	40,517	0	24,114	905,638 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	21,395	1,300	0	0	22,695 8.00
9.00 00900	HOUSEKEEPING	57,609	819	0	5,307	63,735 9.00
10.00 01000	DIETARY	163,308	10,537	0	13,275	187,120 10.00
11.00 01100	CAFETERIA	2,620	0	0	212	2,832 11.00
13.00 01300	NURSING ADMINISTRATION	55,359	595	0	7,725	63,679 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	127,141	633	0	15,854	143,628 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	685,830	19,115	0	76,346	781,291 30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,896	123	0	256	6,275 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	5,487	0	0	0	5,487 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	141,536	174	0	17,586	159,296 65.00
66.00 06600	PHYSICAL THERAPY	1,809,984	13,726	17,124	213,527	2,054,361 66.00
69.00 06900	ELECTROCARDIOLOGY	30,000	0	0	0	30,000 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,047	1,967	0	2,955	121,969 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	312,427	1,265	0	18,103	331,795 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
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	47,422	837	0	5,887	54,146 93.02
93.03 04042	SLEEP LAB	220,857	1,001	0	26,102	247,960 93.03
93.04 04043	PHYSICIANS OFFICE	-5,197	1,676	0	0	-3,521 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)	6,514,330	103,188	17,124	502,393	6,514,330 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	6,514,330	103,188	17,124	502,393	6,514,330 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500	1,335,944					5.00
7.00	00700	233,482	1,139,120				7.00
8.00	00800	5,851	27,537	56,083			8.00
9.00	00900	16,431	17,349	0	97,515		9.00
10.00	01000	48,241	223,243	0	19,895	478,499	10.00
11.00	01100	730	0	0	0	0	11.00
13.00	01300	16,417	12,600	0	1,123	0	13.00
16.00	01600	37,029	13,405	0	1,195	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	201,424	404,972	56,083	36,090	478,499	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	1,618	2,604	0	232	0	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	1,415	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	41,068	3,677	0	328	0	65.00
66.00	06600	529,634	290,802	0	25,915	0	66.00
69.00	06900	7,734	0	0	0	0	69.00
71.00	07100	31,445	41,669	0	3,713	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	85,540	26,809	0	2,389	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	13,959	17,732	0	1,580	0	93.02
93.03	04042	63,926	21,218	0	1,891	0	93.03
93.04	04043	0	35,503	0	3,164	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		1,335,944	1,139,120	56,083	97,515	478,499	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,335,944	1,139,120	56,083	97,515	478,499	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

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						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	3,562					11.00
13.00	01300	61	93,880				13.00
16.00	01600	255	0	195,512			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	926	56,328	58,654	2,074,267	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	2	4,694	0	15,425	0	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	4,694	0	11,596	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	158	12,204	9,776	226,507	0	65.00
66.00	06600	1,680	11,266	107,531	3,021,189	0	66.00
69.00	06900	0	0	0	37,734	0	69.00
71.00	07100	35	0	0	198,831	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	120	0	0	446,653	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	43	4,694	19,551	111,705	0	93.02
93.03	04042	282	0	0	335,277	0	93.03
93.04	04043	0	0	0	35,146	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		3,562	93,880	195,512	6,514,330	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		3,562	93,880	195,512	6,514,330	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Total	
		26.00	
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	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
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
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
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
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
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

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	BLDG & FIXT			
		0	1.00 1.01			
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	0	356	0	356	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	8,547	0	8,547	5.00
7.00 00700	OPERATION OF PLANT	0	40,517	0	40,517	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,300	0	1,300	8.00
9.00 00900	HOUSEKEEPING	0	819	0	819	9.00
10.00 01000	DIETARY	0	10,537	0	10,537	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	595	0	595	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	633	0	633	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	19,115	0	19,115	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	123	0	123	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	174	0	174	65.00
66.00 06600	PHYSICAL THERAPY	0	13,726	17,124	30,850	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,967	0	1,967	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,265	0	1,265	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
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	837	0	837	93.02
93.03 04042	SLEEP LAB	0	1,001	0	1,001	93.03
93.04 04043	PHYSICIANS OFFICE	0	1,676	0	1,676	93.04
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	103,188	17,124	120,312	118.00
NONREIMBURSABLE COST CENTERS						
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	103,188	17,124	120,312	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
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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	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
4.00	00400						4.00
5.00	00500	8,600					5.00
7.00	00700	1,503	42,037				7.00
8.00	00800	38	1,016	2,354			8.00
9.00	00900	106	640	0	1,569		9.00
10.00	01000	311	8,238	0	320	19,415	10.00
11.00	01100	5	0	0	0	0	11.00
13.00	01300	106	465	0	18	0	13.00
16.00	01600	238	495	0	19	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,297	14,946	2,354	582	19,415	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	10	96	0	4	0	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	9	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	264	136	0	5	0	65.00
66.00	06600	3,408	10,731	0	417	0	66.00
69.00	06900	50	0	0	0	0	69.00
71.00	07100	202	1,538	0	60	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	551	989	0	38	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	90	654	0	25	0	93.02
93.03	04042	412	783	0	30	0	93.03
93.04	04043	0	1,310	0	51	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		8,600	42,037	2,354	1,569	19,415	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		8,600	42,037	2,354	1,569	19,415	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
11/29/2012 7:45 pm

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						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	5					11.00
13.00	01300	0	1,189				13.00
16.00	01600	0	0	1,396			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1	714	419	58,897	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	59	0	292	0	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	59	0	68	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	155	70	816	0	65.00
66.00	06600	4	143	767	46,473	0	66.00
69.00	06900	0	0	0	50	0	69.00
71.00	07100	0	0	0	3,769	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	2,856	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	0	0	0	91.00
93.00	04040	0	0	0	0	0	93.00
93.02	04041	0	59	140	1,809	0	93.02
93.03	04042	0	0	0	2,245	0	93.03
93.04	04043	0	0	0	3,037	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		5	1,189	1,396	120,312	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		5	1,189	1,396	120,312	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
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	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
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
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
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
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
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 06/30/2012

Worksheet B-1
Date/Time Prepared:
11/29/2012 7:45 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				
GENERAL SERVICE COST CENTERS						
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	3,600,329		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,728	0	538,511	-1,335,944	5,181,907
7.00 00700	OPERATION OF PLANT	22,414	0	172,806	0	905,638
8.00 00800	LAUNDRY & LINEN SERVICE	719	0	0	0	22,695
9.00 00900	HOUSEKEEPING	453	0	38,031	0	63,735
10.00 01000	DIETARY	5,829	0	95,131	0	187,120
11.00 01100	CAFETERIA	0	0	1,522	0	2,832
13.00 01300	NURSING ADMINISTRATION	329	0	55,359	0	63,679
16.00 01600	MEDICAL RECORDS & LIBRARY	350	0	113,616	0	143,628
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,574	0	547,122	0	781,291
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	68	0	1,833	0	6,275
54.02 05401	IMAGING CENTER	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	0	0	0	0	5,487
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	96	0	126,025	0	159,296
66.00 06600	PHYSICAL THERAPY	7,593	100	1,530,214	0	2,054,361
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	30,000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	21,179	0	121,969
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	700	0	129,733	0	331,795
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.02 04041	NEUROPSYCH OFFICE	463	0	42,188	0	54,146
93.03 04042	SLEEP LAB	554	0	187,059	0	247,960
93.04 04043	PHYSICIANS OFFICE	927	0	0	3,521	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,082	100	3,600,329	-1,332,423	5,181,907
NONREIMBURSABLE COST CENTERS						
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)	103,188	17,124	502,393	1,335,944	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.807715	171.240000	0.139541	0.257809	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			356	8,600	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000099	0.001660	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE 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		
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	29,743				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	719	36,164			8.00	
9.00	00900	HOUSEKEEPING	453	0	28,571		9.00	
10.00	01000	DIETARY	5,829	0	5,829	9,438	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	329	0	329	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	350	0	350	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,574	36,164	10,574	9,438	19,770	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	0	68	0	42	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	96	0	96	0	3,374	65.00
66.00	06600	PHYSICAL THERAPY	7,593	0	7,593	0	35,880	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	1,088	0	754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	700	0	700	0	2,552	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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	463	0	463	0	911	93.02
93.03	04042	SLEEP LAB	554	0	554	0	6,022	93.03
93.04	04043	PHYSICIANS OFFICE	927	0	927	0	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)	29,743	36,164	28,571	9,438	76,056	118.00
NONREIMBURSABLE COST CENTERS								
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,139,120	56,083	97,515	478,499	3,562	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.298759	1.550796	3.413076	50.699195	0.046834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,037	2,354	1,569	19,415	5	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.413341	0.065092	0.054916	2.057110	0.000066	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet B-1
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	16.00	
GENERAL SERVICE COST CENTERS				
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	1,000	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	60	300	30.00
ANCILLARY SERVICE COST CENTERS				
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	13	50	65.00
66.00	06600	12	550	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
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	0	0	88.00
89.00	08900	0	0	89.00
91.00	09100	0	0	91.00
93.00	04040	0	0	93.00
93.02	04041	5	100	93.02
93.03	04042	0	0	93.03
93.04	04043	0	0	93.04
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
118.00		100	1,000	118.00
NONREIMBURSABLE COST CENTERS				
200.00				200.00
201.00				201.00
202.00		93,880	195,512	202.00
203.00		938.800000	195.512000	203.00
204.00		1,189	1,396	204.00
205.00		11.890000	1.396000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE		
					Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,074,267		2,074,267	0	2,074,267	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,425		15,425	0	15,425	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	11,596		11,596	0	11,596	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	226,507	0	226,507	0	226,507	65.00
66.00	06600 PHYSICAL THERAPY	3,021,189	0	3,021,189	0	3,021,189	66.00
69.00	06900 ELECTROCARDIOLOGY	37,734		37,734	0	37,734	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	198,831		198,831	0	198,831	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	446,653		446,653	0	446,653	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
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	111,705		111,705	0	111,705	93.02
93.03	04042 SLEEP LAB	335,277		335,277	12,067	347,344	93.03
93.04	04043 PHYSICIANS OFFICE	35,146		35,146	0	35,146	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
200.00	Subtotal (see instructions)	6,514,330	0	6,514,330	12,067	6,526,397	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	6,514,330	0	6,514,330	12,067	6,526,397	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,669,930		2,669,930			30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	60,021	0	60,021	0.256993	0.000000	54.00
54.02	05401 IMAGING CENTER	0	0	0	0.000000	0.000000	54.02
57.00	05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000 LABORATORY	582,895	4,104	586,999	0.019755	0.000000	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	364,973	14,795	379,768	0.596435	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	1,513,396	5,375,760	6,889,156	0.438543	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	69,738	0	69,738	0.541082	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183,334	0	183,334	1.084529	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	513,919	29	513,948	0.869063	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.02	04041 NEUROPSYCH OFFICE	139,290	58,218	197,508	0.565572	0.000000	93.02
93.03	04042 SLEEP LAB	0	1,975,272	1,975,272	0.169737	0.000000	93.03
93.04	04043 PHYSICIANS OFFICE	0	0	0	0.000000	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0			99.10
200.00	Subtotal (see instructions)	6,097,496	7,428,178	13,525,674			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6,097,496	7,428,178	13,525,674			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256993			54.00
54.02	05401 IMAGING CENTER	0.000000			54.02
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.019755			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.596435			65.00
66.00	06600 PHYSICAL THERAPY	0.438543			66.00
69.00	06900 ELECTROCARDIOLOGY	0.541082			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.084529			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.869063			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100 EMERGENCY	0.000000			91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.02	04041 NEUROPSYCH OFFICE	0.565572			93.02
93.03	04042 SLEEP LAB	0.175846			93.03
93.04	04043 PHYSICIANS OFFICE	0.000000			93.04
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,074,267		2,074,267	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	15,425		15,425	0	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	11,596		11,596	0	0	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	226,507	0	226,507	0	0	65.00
66.00	06600 PHYSICAL THERAPY	3,021,189	0	3,021,189	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	37,734		37,734	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	198,831		198,831	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	446,653		446,653	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
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	111,705		111,705	0	0	93.02
93.03	04042 SLEEP LAB	335,277		335,277	0	0	93.03
93.04	04043 PHYSICIANS OFFICE	35,146		35,146	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0		0	99.10
200.00	Subtotal (see instructions)	6,514,330	0	6,514,330	0	0	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	6,514,330	0	6,514,330	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,669,930		2,669,930		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,021	0	60,021	0.256993	54.00
54.02	05401	IMAGING CENTER	0	0	0	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	582,895	4,104	586,999	0.019755	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	364,973	14,795	379,768	0.596435	65.00
66.00	06600	PHYSICAL THERAPY	1,513,396	5,375,760	6,889,156	0.438543	66.00
69.00	06900	ELECTROCARDIOLOGY	69,738	0	69,738	0.541082	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,334	0	183,334	1.084529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	513,919	29	513,948	0.869063	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
93.02	04041	NEUROPSYCH OFFICE	139,290	58,218	197,508	0.565572	93.02
93.03	04042	SLEEP LAB	0	1,975,272	1,975,272	0.169737	93.03
93.04	04043	PHYSICIANS OFFICE	0	0	0	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
200.00		Subtotal (see instructions)	6,097,496	7,428,178	13,525,674		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,097,496	7,428,178	13,525,674		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.02	05401 IMAGING CENTER	0.000000			54.02
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	09100 EMERGENCY	0.000000			91.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.02	04041 NEUROPSYCH OFFICE	0.000000			93.02
93.03	04042 SLEEP LAB	0.000000			93.03
93.04	04043 PHYSICIANS OFFICE	0.000000			93.04
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 153039		Period: From 01/01/2012 To 06/30/2012		Worksheet D Part I Date/Time Prepared: 11/29/2012 7:45 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,897	0	58,897	3,146	18.72	30.00
200.00		Total (Lines 30-199)	58,897		58,897	3,146		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D Part I Date/Time Prepared: 11/29/2012 7:45 pm
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,712	50,769	30.00
200.00		Total (lines 30-199)	2,712	50,769	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 11/29/2012 7:45 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	292	60,021	0.004865	0	0	54.00
54.02	05401	IMAGING CENTER	0	0	0.000000	0	0	54.02
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	68	586,999	0.000116	569,023	66	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	816	379,768	0.002149	328,816	707	65.00
66.00	06600	PHYSICAL THERAPY	46,473	6,889,156	0.006746	1,297,299	8,752	66.00
69.00	06900	ELECTROCARDIOLOGY	50	69,738	0.000717	65,658	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,769	183,334	0.020558	158,885	3,266	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	2,856	513,948	0.005557	445,991	2,478	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
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	1,809	197,508	0.009159	0	0	93.02
93.03	04042	SLEEP LAB	2,245	1,975,272	0.001137	0	0	93.03
93.04	04043	PHYSICIANS OFFICE	3,037	0	0.000000	0	0	93.04
200.00		Total (lines 50-199)	61,415	10,855,744		2,865,672	15,316	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 153039		Period: From 01/01/2012 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/29/2012 7:45 pm	
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	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 153039		Period: From 01/01/2012 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/29/2012 7:45 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,146	0.00	2,712	0	30.00	
200.00		Total (lines 30-199)	3,146		2,712	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.02	05401	IMAGING CENTER	0	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
93.02	04041	NEUROPSYCH OFFICE	0	0	0	0	0	0	93.02
93.03	04042	SLEEP LAB	0	0	0	0	0	0	93.03
93.04	04043	PHYSICIANS OFFICE	0	0	0	0	0	0	93.04
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
			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)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,021	0.000000	0.000000	0	54.00
54.02	05401	IMAGING CENTER	0	0	0.000000	0.000000	0	54.02
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	586,999	0.000000	0.000000	569,023	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	379,768	0.000000	0.000000	328,816	65.00
66.00	06600	PHYSICAL THERAPY	0	6,889,156	0.000000	0.000000	1,297,299	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69,738	0.000000	0.000000	65,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,334	0.000000	0.000000	158,885	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	513,948	0.000000	0.000000	445,991	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
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	197,508	0.000000	0.000000	0	93.02
93.03	04042	SLEEP LAB	0	1,975,272	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	10,855,744			2,865,672	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
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	2,783	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,268	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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	0	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	658,271	0	93.03
93.04	04043	PHYSICIANS OFFICE	0	0	0	93.04
200.00		Total (lines 50-199)	0	667,322	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:45 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
		1.00	2.00	3.00				
ANCILLARY SERVICE COST CENTERS								
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.256993	0	0	0	0	0	54.00
54.02 05401	IMAGING CENTER	0.000000	0	0	0	0	0	54.02
57.00 05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0.019755	0	0	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0.596435	2,783	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0.438543	6,268	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0.541082	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.084529	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.869063	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00 08800	RURAL HEALTH CLINIC	0.000000						88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000						89.00
91.00 09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	0	93.00
93.02 04041	NEUROPSYCH OFFICE	0.565572	0	0	0	0	0	93.02
93.03 04042	SLEEP LAB	0.169737	658,271	0	0	0	0	93.03
93.04 04043	PHYSICIANS OFFICE	0.000000	0	0	0	0	0	93.04
200.00	Subtotal (see instructions)		667,322	0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		667,322	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:45 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
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	1,660	0	0	65.00
66.00 06600	PHYSICAL THERAPY	2,749	0	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					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 09100	EMERGENCY	0	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	111,733	0	0	93.03
93.04 04043	PHYSICIANS OFFICE	0	0	0	93.04
200.00	Subtotal (see instructions)	116,142	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	116,142	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D-1
		Title XVIII	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,146	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,146	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,146	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)		2,712	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,074,267	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)		2,074,267	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,669,930	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,669,930	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.776899	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)		848.67	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,074,267	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		659.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,788,103	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,788,103	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2012 To 06/30/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/29/2012 7:45 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						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)					1,371,714	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,159,817	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)					50,769	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,316	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					66,085	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,093,732	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 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/29/2012 7:45 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	58,897	2,074,267	0.028394	0	0	90.00
91.00	Nursing School cost	0	2,074,267	0.000000	0	0	91.00
92.00	Allied health cost	0	2,074,267	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,074,267	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/29/2012 7:45 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,146	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,146	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,146	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)		19	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,074,267	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)		2,074,267	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,669,930	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,669,930	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.776899	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)		848.67	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,074,267	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		659.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,527	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)		12,527	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2012 To 06/30/2012		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 11/29/2012 7:45 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)					13,186	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,713	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					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 06/30/2012

Worksheet D-1

Date/Time Prepared:
11/29/2012 7:45 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/29/2012 7:45 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		2,302,044		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256993	0	0	54.00
54.02	05401 IMAGING CENTER	0.000000	0	0	54.02
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.019755	569,023	11,241	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.596435	328,816	196,117	65.00
66.00	06600 PHYSICAL THERAPY	0.438543	1,297,299	568,921	66.00
69.00	06900 ELECTROCARDIOLOGY	0.541082	65,658	35,526	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.084529	158,885	172,315	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.869063	445,991	387,594	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
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	0.565572	0	0	93.02
93.03	04042 SLEEP LAB	0.175846	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)		2,865,672	1,371,714	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,865,672		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/29/2012 7:45 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		23,713		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256993	0	0	54.00
54.02	05401 IMAGING CENTER	0.000000	0	0	54.02
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.019755	3,093	61	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.596435	1,057	630	65.00
66.00	06600 PHYSICAL THERAPY	0.438543	13,509	5,924	66.00
69.00	06900 ELECTROCARDIOLOGY	0.541082	558	302	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.084529	908	985	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.869063	5,481	4,763	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
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	0.565572	921	521	93.02
93.03	04042 SLEEP LAB	0.169737	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)		25,527	13,186	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)		25,527		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/29/2012 7:45 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		116,142	2.00
3.00	PPS payments		133,802	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
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		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)		133,802	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		45,507	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)		88,295	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)		88,295	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		88,295	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		11,426	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		7,998	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,426	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		96,293	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		96,293	40.00
41.00	Interim payments		88,295	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)		7,998	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2012 7:45 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		3,258,199		88,295	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,258,199		88,295	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		20,131		7,998	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,278,330		96,293	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 06/30/2012	Worksheet E-3 Part III Date/Time Prepared: 11/29/2012 7:45 pm
		Title XVII	Hospital	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,303,874 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0242 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			68,037 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
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)			17.285714 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)			3,379,662 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)			3,379,662 17.00
18.00	Primary payer payments			4,619 18.00
19.00	Subtotal (line 17 less line 18).			3,375,043 19.00
20.00	Deductibles			99,296 20.00
21.00	Subtotal (line 19 minus line 20)			3,275,747 21.00
22.00	Coinurance			5,202 22.00
23.00	Subtotal (line 21 minus line 22)			3,270,545 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			11,122 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			7,785 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			5,756 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,278,330 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)			3,278,330 32.00
33.00	Interim payments			3,258,199 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)			20,131 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			10,000 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			0 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2012 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2012 7:45 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		25,713	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		25,713	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		25,713	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		49,239	8.00
9.00	Ancillary service charges		25,527	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		74,766	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		74,766	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		49,053	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		25,713	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		25,713	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		25,713	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		25,713	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		25,713	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		25,713	40.00
41.00	Interim payments		6,167	41.00
42.00	Balance due provider/program (line 40 minus 41)		19,546	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet G

Date/Time Prepared:
11/29/2012 7:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,269,841	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	1,181,312	0	0	0	4.00
5.00	Other receivable	10,103	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	239,625	0	0	0	7.00
8.00	Prepaid expenses	0	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)	2,700,881	0	0	0	11.00
FIXED ASSETS						
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	1,392,288	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	0	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)	1,392,288	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	565,097	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	565,097	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,658,266	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	408,549	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	637,697	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,046,246	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	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)	1,046,246	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,612,020				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)	3,612,020	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,658,266	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/29/2012 7:45 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		3,259,262		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		352,760			2.00
3.00	Total (sum of line 1 and line 2)		3,612,022		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)		3,612,022		0	11.00
12.00	ROUNDING	2		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)		2		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,612,020		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/29/2012 7:45 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00		0			0	10.00
11.00		0			0	11.00
12.00	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		0			0	18.00
19.00		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2012 7:45 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,669,930		2,669,930	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)	2,669,930		2,669,930	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)	2,669,930		2,669,930	17.00
18.00	Ancillary services	3,427,566	7,428,178	10,855,744	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)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,097,496	7,428,178	13,525,674	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		6,466,130		29.00
30.00		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)		6,466,130		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153039

Period:
From 01/01/2012
To 06/30/2012

Worksheet G-3

Date/Time Prepared:
11/29/2012 7:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	13,525,674	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,179,449	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,346,225	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	6,466,130	4.00
5.00	Net income from service to patients (line 3 minus line 4)	880,095	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	56,868	24.00
24.01	NON OPERATING REVENUE	797	24.01
24.02		-585,000	24.02
25.00	Total other income (sum of lines 6-24)	-527,335	25.00
26.00	Total (line 5 plus line 25)	352,760	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	352,760	29.00