

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: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 6/11/2013 2:37 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2013	Time: 4:13 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLACKFORD HOSPITAL (151302) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	177,534	-72,727	488,335	207,760	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	225,219	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	402,753	-72,727	488,335	207,760	200.00

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

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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.

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Encryption Information
 ECR: Date: 5/30/2013 Time: 4:13 pm
 7S: QmMuQNTz9E0ovHva3jvSEI aASkO
 6l wxM0cCI XmqhUZhm2j WwXF4PMYETY
 QSg50LWSa10I zPI m
 PI: Date: 5/30/2013 Time: 4:13 pm
 w7uEBI NU9sGi KqqFxmAFi hr10nMxbO
 OAsFy0Er2y0mcnse7oJWq. i zkHzTE1n
 mryz06nvgy0ZGrBR

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00		
		Part A 2.00	Part B 3.00				
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	177,534	-72,727	488,335	207,760	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	0	4.00
5.00	Swing bed - SNF	0	225,219	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	0	12.00
200.00	Total	0	402,753	-72,727	488,335	207,760	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 151302		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 6/11/2013 2:37 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 410 PILGRIM STREET			PO Box:							1.00
2.00	City: HARTFORD CITY			State: IN		Zip Code: 47348		County: BLACKFORD			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		IU HEALTH BLACKFORD HOSPITAL	151302	99915	1	02/10/2000	N	0	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		BLACKFORD COMMUNITY SWING BED	15Z302	99915		02/01/2000	N	0	0	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 6/11/2013 2:37 pm
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00

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

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

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

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	
119.00	DO NOT USE THIS LINE			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H059
		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: IU HEALTH, INC	Contractor's Name: WPS		Contractor's Number: 08101
142.00	Street: 340 W. 10TH STREET	PO Box:		
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46204
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?			Y
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N
				1.00
				2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N
		Part A	Part B	Title V
		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
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N
161.10	CORF		N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151302		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 6/11/2013 2:37 pm		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						495,160	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 6/11/2013 2:37 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)	Y			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	R	03/31/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	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)	Y	04/19/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 6/11/2013 2:37 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	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.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	04/19/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, COST REPORTING	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 6/11/2013 2:37 pm
		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151302

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

Worksheet S-3
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	15	5,490	37,608.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		15	5,490	37,608.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		15	5,490	37,608.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		15				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
	I/P Days / O/P Visi ts / Trips			Full Time Equivalents		
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,216	97	1,567			1.00
2.00 HMO	16	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,248	10	1,470			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,464	107	3,037			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	2,464	107	3,037	0.00	211.97	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151302

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

Worksheet S-3
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	211.97	27.00
28.00	Observation Bed Days		0	294			28.00
29.00	Ambulance Trips	1,160					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
		11.00	12.00	13.00	14.00		15.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	310	55	606	1.00
2.00	HMO			4			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	310	55	606	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 6/11/2013 2:37 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.429308	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		859,856	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		5,945,983	6.00
7.00	Medicaid cost (line 1 times line 6)		2,552,658	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,692,802	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,692,802	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,444,264	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		154,901	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,289,363	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		553,534	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		553,534	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,246,336	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151302

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

Worksheet A
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		1,208,748	1,208,748	-68,249	1,140,499	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS	12,623	202,842	215,465	-3,590	211,875	4.00
5.01 00540 ADMINISTRATION	368,688	6,789	375,477	0	375,477	5.01
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL	361,230	3,399,837	3,761,067	0	3,761,067	5.02
7.00 00700 OPERATION OF PLANT	145,105	403,039	548,144	-218	547,926	7.00
9.00 00900 HOUSEKEEPING	145,571	134,517	280,088	-21,357	258,731	9.00
10.00 01000 DIETARY	140,519	137,629	278,148	-173,252	104,896	10.00
11.00 01100 CAFETERIA	0	0	0	172,650	172,650	11.00
13.00 01300 NURSING ADMINISTRATION	171,721	29,982	201,703	-157	201,546	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	55,314	4,593	59,907	544,710	604,617	14.00
15.00 01500 PHARMACY	0	770,831	770,831	-383,968	386,863	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,544,173	244,710	1,788,883	-44,251	1,744,632	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	271,147	183,345	454,492	-106,150	348,342	50.00
53.00 05300 ANESTHESIOLOGY	0	110,291	110,291	-17,202	93,089	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	449,660	517,154	966,814	-31,693	935,121	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	630,572	584,248	1,214,820	-270,805	944,015	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	367,162	68,236	435,398	-35,647	399,751	65.00
65.01 06501 SLEEP LAB	0	41,424	41,424	0	41,424	65.01
66.00 06600 PHYSICAL THERAPY	207,713	58,846	266,559	-2,552	264,007	66.00
67.00 06700 OCCUPATIONAL THERAPY	76,155	0	76,155	0	76,155	67.00
68.00 06800 SPEECH PATHOLOGY	3,256	0	3,256	0	3,256	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	46,752	46,752	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,740	7,740	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	386,199	386,199	73.00
76.00 03020 RADIOLOGY	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	75,698	10,858	86,556	-1,173	85,383	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	81,855	8,848	90,703	-1,854	88,849	90.00
91.00 09100 EMERGENCY	1,377,497	756,359	2,133,856	-21,586	2,112,270	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	874,154	333,644	1,207,798	25,653	1,233,451	95.00
99.10 09910 CORF	0	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,359,813	9,216,770	16,576,583	0	16,576,583	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 07952 PHARMACY	0	0	0	0	0	194.02
200.00 TOTAL (SUM OF LINES 118-199)	7,359,813	9,216,770	16,576,583	0	16,576,583	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151302

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

Worksheet A
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	225,763	1,366,262	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	175,142	387,017	4.00
5.01	00540	ADMINISTRATIVE	219,736	595,213	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	2,960,492	6,721,559	5.02
7.00	00700	OPERATION OF PLANT	-23,990	523,936	7.00
9.00	00900	HOUSEKEEPING	13,724	272,455	9.00
10.00	01000	DIETARY	-1,459	103,437	10.00
11.00	01100	CAFETERIA	-66,210	106,440	11.00
13.00	01300	NURSING ADMINISTRATION	-275	201,271	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	604,617	14.00
15.00	01500	PHARMACY	0	386,863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,744,632	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	348,342	50.00
53.00	05300	ANESTHESIOLOGY	-93,674	-585	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,680	918,441	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-754,877	189,138	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	-4,000	395,751	65.00
65.01	06501	SLEEP LAB	0	41,424	65.01
66.00	06600	PHYSICAL THERAPY	-1,310	262,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	76,155	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,256	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,740	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	386,199	73.00
76.00	03020	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	85,383	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	88,849	90.00
91.00	09100	EMERGENCY	-499,195	1,613,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-82,170	1,151,281	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,051,017	18,627,600	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
194.02	07952	PHARMACY	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	2,051,017	18,627,600	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet Non-CMS W Date/Time Prepared: 6/11/2013 2:37 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.01	ADMINISTRATIVE	00540		5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	00560		5.02
7.00	OPERATION OF PLANT	00700		7.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	06501		65.01
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	CARDIOLOGY	03020		76.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
99.10	CORF	09910		99.10
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.01	OTHER NONREIMBURSABLE COST CENTERS	07951		194.01
194.02	PHARMACY	07952		194.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	87,222	85,428	1.00
	TOTALS		87,222	85,428	
B - SUPPLIES CHARGED TO PATIENTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	544,710	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	46,752	2.00
3.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	7,740	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
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	599,202	
C - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	386,199	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
	TOTALS		0	386,199	
D - PHARMACY					
1.00	PHARMACY	15.00	0	25,531	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	25,531	
E - AMBULANCE DEPRECIATION					
1.00	AMBULANCE SERVICES	95.00	0	68,249	1.00
	TOTALS		0	68,249	
500.00	Grand Total: Increases		87,222	1,164,609	500.00

RECLASSIFICATIONS

Provider CCN: 151302

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

Worksheet A-6

Date/Time Prepared:
6/11/2013 2:37 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	87,222	85,428	0	1.00
	TOTALS		87,222	85,428		
B - SUPPLIES CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS	4.00	0	673	0	1.00
2.00	OPERATION OF PLANT	7.00	0	218	0	2.00
3.00	HOUSEKEEPING	9.00	0	21,357	0	3.00
4.00	DIETARY	10.00	0	602	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	157	0	5.00
6.00	PHARMACY	15.00	0	62,531	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	43,781	0	7.00
8.00	OPERATING ROOM	50.00	0	104,723	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	16,192	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,112	0	10.00
11.00	LABORATORY	60.00	0	227,131	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	35,395	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	2,552	0	13.00
14.00	CARDIAC REHABILITATION	76.97	0	1,173	0	14.00
15.00	CLINIC	90.00	0	1,842	0	15.00
16.00	EMERGENCY	91.00	0	21,206	0	16.00
17.00	AMBULANCE SERVICES	95.00	0	28,557	0	17.00
	TOTALS		0	599,202		
C - DRUGS CHARGED TO PATIENTS						
1.00	EMPLOYEE BENEFITS	4.00	0	2,917	0	1.00
2.00	PHARMACY	15.00	0	346,968	0	2.00
3.00	OPERATING ROOM	50.00	0	1,369	0	3.00
4.00	LABORATORY	60.00	0	28,980	0	4.00
5.00	AMBULANCE SERVICES	95.00	0	5,965	0	5.00
	TOTALS		0	386,199		
D - PHARMACY						
1.00	ADULTS & PEDIATRICS	30.00	0	470	0	1.00
2.00	OPERATING ROOM	50.00	0	58	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	1,010	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	581	0	4.00
5.00	LABORATORY	60.00	0	14,694	0	5.00
6.00	RESPIRATORY THERAPY	65.00	0	252	0	6.00
7.00	CLINIC	90.00	0	12	0	7.00
8.00	EMERGENCY	91.00	0	380	0	8.00
9.00	AMBULANCE SERVICES	95.00	0	8,074	0	9.00
	TOTALS		0	25,531		
E - AMBULANCE DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	68,249	9	1.00
	TOTALS		0	68,249		
500.00	Grand Total: Decreases		87,222	1,164,609		500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - CAFETERIA						
1.00	CAFETERIA	11.00	DIETARY	10.00	87,222	1.00
	TOTALS	87,222	TOTALS		87,222	
B - SUPPLIES CHARGED TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	EMPLOYEE BENEFITS	4.00	0	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	OPERATION OF PLANT	7.00	0	2.00
3.00	IMPL. DEV. CHARGED TO PATIENT	72.00	HOUSEKEEPING	9.00	0	3.00
4.00		0.00	DIETARY	10.00	0	4.00
5.00		0.00	NURSING ADMINISTRATION	13.00	0	5.00
6.00		0.00	PHARMACY	15.00	0	6.00
7.00		0.00	ADULTS & PEDIATRICS	30.00	0	7.00
8.00		0.00	OPERATING ROOM	50.00	0	8.00
9.00		0.00	ANESTHESIOLOGY	53.00	0	9.00
10.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10.00
11.00		0.00	LABORATORY	60.00	0	11.00
12.00		0.00	RESPIRATORY THERAPY	65.00	0	12.00
13.00		0.00	PHYSICAL THERAPY	66.00	0	13.00
14.00		0.00	CARDIAC REHABILITATION	76.97	0	14.00
15.00		0.00	CLINIC	90.00	0	15.00
16.00		0.00	EMERGENCY	91.00	0	16.00
17.00		0.00	AMBULANCE SERVICES	95.00	0	17.00
	TOTALS		TOTALS		0	
C - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	EMPLOYEE BENEFITS	4.00	0	1.00
2.00		0.00	PHARMACY	15.00	0	2.00
3.00		0.00	OPERATING ROOM	50.00	0	3.00
4.00		0.00	LABORATORY	60.00	0	4.00
5.00		0.00	AMBULANCE SERVICES	95.00	0	5.00
	TOTALS		TOTALS		0	
D - PHARMACY						
1.00	PHARMACY	15.00	ADULTS & PEDIATRICS	30.00	0	1.00
2.00		0.00	OPERATING ROOM	50.00	0	2.00
3.00		0.00	ANESTHESIOLOGY	53.00	0	3.00
4.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4.00
5.00		0.00	LABORATORY	60.00	0	5.00
6.00		0.00	RESPIRATORY THERAPY	65.00	0	6.00
7.00		0.00	CLINIC	90.00	0	7.00
8.00		0.00	EMERGENCY	91.00	0	8.00
9.00		0.00	AMBULANCE SERVICES	95.00	0	9.00
	TOTALS		TOTALS		0	
E - AMBULANCE DEPRECIATION						
1.00	AMBULANCE SERVICES	95.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
	TOTALS		TOTALS		0	
500.00	Grand Total: Increases		Grand Total: Decreases		87,222	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151302

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

Worksheet A-7
Part I
Date/Time Prepared:
6/11/2013 2:37 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	190,324	0	0	0	1.00
2.00	Land Improvements	275,335	0	0	0	2.00
3.00	Buildings and Fixtures	14,859,870	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,388,593	0	0	198,309	6.00
7.00	HIT designated Assets	495,160	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,209,282	0	0	198,309	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,209,282	0	0	198,309	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	190,324	0			1.00
2.00	Land Improvements	275,335	0			2.00
3.00	Buildings and Fixtures	14,859,870	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,190,284	0			6.00
7.00	HIT designated Assets	495,160	0			7.00
8.00	Subtotal (sum of lines 1-7)	21,010,973	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	21,010,973	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151302

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

Worksheet A-7
Part II
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,196,628	0	0	12,120	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,196,628	0	0	12,120	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,208,748				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,208,748				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151302

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

Worksheet A-7
Part III
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	15,325,529	0	15,325,529	0.722586	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,883,753	0	5,883,753	0.277414	0	2.00
3.00	Total (sum of lines 1-2)	21,209,282	0	21,209,282	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,354,142	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,354,142	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12,120	0	0	1,366,262	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	12,120	0	0	1,366,262	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151302

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

Worksheet A-8

Date/Time Prepared:
6/11/2013 2:37 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 #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT		1.00	0 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-653,970				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	3,951,231				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-69,656	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines	B	-1,459	DIETARY		10.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 IHHA AND AHA LOBBY COSTS	A	-1,968	OTHER ADMINISTRATIVE AND GENERAL		5.02	0 33.00

Provider CCN: 151302

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

Worksheet A-8

Date/Time Prepared:
 6/11/2013 2:37 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
34.00	MARKETING ADVERTISING COSTS	A	-15,113	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.00
35.00	HAF ASSESSMENT FEE	A	-1,019,347	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	NON ALLOW INTEREST EXP	A	-36,380	OTHER ADMINISTRATIVE AND GENERAL	5.02	11	36.00
37.00	PATIENT PHONE COSTS	A	-3,118	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	MISCELL INCOME	B	-70,609	OTHER ADMINISTRATIVE AND GENERAL	5.02	9	38.00
39.00	MISCELL INCOME	B	-23,009	OPERATION OF PLANT	7.00	0	39.00
40.00	MISCELL INCOME	B	-275	NURSING ADMINISTRATION	13.00	0	40.00
41.00	MISCELL INCOME	B	-4,000	RESPIRATORY THERAPY	65.00	0	41.00
42.00	MISCELL INCOME	B	-1,310	PHYSICAL THERAPY	66.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,051,017				50.00

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

Provider CCN: 151302

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

Worksheet A-8-1

Date/Time Prepared: 6/11/2013 2:37 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	225,763	0	1.00
2.00	4.00	EMPLOYEE BENEFITS	183,070	7,928	2.00
3.00	5.01	ADMINISTRATIVE	219,736	0	3.00
4.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	5,557,258	1,450,231	4.00
4.01	7.00	OPERATION OF PLANT	55,664	56,645	4.01
4.02	9.00	HOUSEKEEPING	13,724	0	4.02
4.03	11.00	CAFETERIA	3,446	0	4.03
4.04	95.00	AMBULANCE SERVICES	0	73,749	4.04
4.05	60.00	LABORATORY	156,483	875,360	4.05
4.06	5.02	OTHER ADMINISTRATIVE AND GENERAL	1,040,942	1,040,942	4.06
4.07	5.01	ADMINISTRATIVE	277,776	277,776	4.07
4.08	7.00	OPERATION OF PLANT	28	28	4.08
4.09	10.00	DIETARY	11,363	11,363	4.09
4.10	15.00	PHARMACY	315,044	315,044	4.10
4.11	30.00	ADULTS & PEDIATRICS	42,194	42,194	4.11
4.12	50.00	OPERATING ROOM	10,874	10,874	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	239,264	239,264	4.13
4.14	60.00	LABORATORY	3,105	3,105	4.14
4.15	65.00	RESPIRATORY THERAPY	2,811	2,811	4.15
4.16	65.01	SLEEP LAB	40,464	40,464	4.16
4.17	66.00	PHYSICAL THERAPY	208,274	208,274	4.17
4.18	67.00	OCCUPATIONAL THERAPY	76,155	76,155	4.18
4.19	68.00	SPEECH PATHOLOGY	3,256	3,256	4.19
4.20	76.97	CARDIAC REHABILITATION	699	699	4.20
4.21	90.00	CLINIC	231	231	4.21
4.22	91.00	EMERGENCY	5,250	5,250	4.22
4.23	95.00	AMBULANCE SERVICES	6,812	6,812	4.23
5.00	0	0	8,699,686	4,748,455	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 151302

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

Worksheet A-8-1

Date/Time Prepared:
6/11/2013 2:37 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	225,763	9		1.00
2.00	175,142	0		2.00
3.00	219,736	0		3.00
4.00	4,107,027	0		4.00
4.01	-981	0		4.01
4.02	13,724	0		4.02
4.03	3,446	0		4.03
4.04	-73,749	0		4.04
4.05	-718,877	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
5.00	3,951,231			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151302

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

Worksheet A-8-2

Date/Time Prepared:
6/11/2013 2:37 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	93,674	93,674	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	16,680	16,680	0	0	0	2.00
3.00	60.00	LABORATORY	36,000	36,000	0	0	0	3.00
4.00	91.00	EMERGENCY	499,195	499,195	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	8,421	8,421	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			653,970	653,970	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	93,674	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	16,680	2.00
3.00	60.00	LABORATORY	0	0	0	36,000	3.00
4.00	91.00	EMERGENCY	0	0	0	499,195	4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	8,421	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	653,970	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,366,262	1,366,262				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00 00400 EMPLOYEE BENEFITS	387,017	0		0	387,017	4.00
5.01 00540 ADMITTING	595,213	0		0	19,421	614,634 5.01
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL	6,721,559	104,765		0	19,028	0 5.02
7.00 00700 OPERATION OF PLANT	523,936	430,563		0	7,644	0 7.00
9.00 00900 HOUSEKEEPING	272,455	19,155		0	7,668	0 9.00
10.00 01000 DIETARY	103,437	18,909		0	2,807	0 10.00
11.00 01100 CAFETERIA	106,440	50,114		0	4,595	0 11.00
13.00 01300 NURSING ADMINISTRATION	201,271	4,181		0	9,046	0 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	604,617	21,997		0	2,914	0 14.00
15.00 01500 PHARMACY	386,863	14,947		0	0	0 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	20,986		0	0	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,744,632	207,617		0	81,336	51,610 30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	0 31.00
41.00 04100 SUBPROVIDER - IRF	0	0		0	0	0 41.00
42.00 04200 SUBPROVIDER	0	0		0	0	0 42.00
43.00 04300 NURSERY	0	0		0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	348,342	142,446		0	14,283	47,696 50.00
53.00 05300 ANESTHESIOLOGY	-585	0		0	0	1,772 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	918,441	110,777		0	23,686	135,377 54.00
57.00 05700 CT SCAN	0	0		0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		0	0	0 59.00
60.00 06000 LABORATORY	189,138	30,222		0	33,216	135,278 60.00
60.01 06001 BLOOD LABORATORY	0	0		0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	395,751	22,680		0	19,341	19,668 65.00
65.01 06501 SLEEP LAB	41,424	0		0	0	5,271 65.01
66.00 06600 PHYSICAL THERAPY	262,697	0		0	10,941	16,057 66.00
67.00 06700 OCCUPATIONAL THERAPY	76,155	0		0	4,012	822 67.00
68.00 06800 SPEECH PATHOLOGY	3,256	0		0	172	271 68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	46,752	0		0	0	954 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7,740	0		0	7,740	569 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	386,199	0		0	0	56,761 73.00
76.00 03020 RADIOLOGY	0	0		0	0	0 76.00
76.97 07697 CARDIAC REHABILITATION	85,383	3,826		0	3,987	2,662 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0 89.00
90.00 09000 CLINIC	88,849	51,863		0	4,312	730 90.00
91.00 09100 EMERGENCY	1,613,075	104,055		0	72,561	72,378 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	1,151,281	0		0	46,047	66,758 95.00
99.10 09910 CORF	0	0		0	0	0 99.10
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0	0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0		0	0	0 111.00
113.00 11300 INTEREST EXPENSE	0	0		0	0	0 113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	18,627,600	1,359,103		0	387,017	614,634 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,159		0	0	0 190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	0	0 192.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	0 194.00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	0 194.01
194.02 07952 PHARMACY	0	0		0	0	0 194.02
200.00 Cross Foot Adjustments	0	0		0	0	200.00
201.00 Negative Cost Centers	0	0		0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	18,627,600	1,366,262		0	387,017	614,634 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	
		5A. 01	5. 02	7. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS							
1. 00	00100						1. 00
2. 00	00200						2. 00
4. 00	00400						4. 00
5. 01	00540						5. 01
5. 02	00560	6, 845, 352	6, 845, 352				5. 02
7. 00	00700	962, 143	558, 994	1, 521, 137			7. 00
9. 00	00900	299, 278	173, 877	35, 066	508, 221		9. 00
10. 00	01000	125, 153	72, 713	34, 616	11, 838	244, 320	10. 00
11. 00	01100	161, 149	93, 626	91, 741	31, 375		0 11. 00
13. 00	01300	214, 498	124, 621	7, 653	2, 617		0 13. 00
14. 00	01400	629, 528	365, 749	40, 268	13, 771		0 14. 00
15. 00	01500	401, 810	233, 447	27, 362	9, 358		0 15. 00
16. 00	01600	20, 986	12, 193	38, 417	13, 138		0 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000	2, 085, 195	1, 211, 470	380, 072	129, 981	244, 320	30. 00
31. 00	03100	0	0	0	0	0	0 31. 00
41. 00	04100	0	0	0	0	0	0 41. 00
42. 00	04200	0	0	0	0	0	0 42. 00
43. 00	04300	0	0	0	0	0	0 43. 00
ANCILLARY SERVICE COST CENTERS							
50. 00	05000	552, 767	321, 152	260, 768	89, 180	0	0 50. 00
53. 00	05300	1, 187	690	0	0	0	0 53. 00
54. 00	05400	1, 188, 281	690, 378	202, 792	69, 353	0	0 54. 00
57. 00	05700	0	0	0	0	0	0 57. 00
58. 00	05800	0	0	0	0	0	0 58. 00
59. 00	05900	0	0	0	0	0	0 59. 00
60. 00	06000	387, 854	225, 339	55, 325	18, 921	0	0 60. 00
60. 01	06001	0	0	0	0	0	0 60. 01
62. 00	06200	0	0	0	0	0	0 62. 00
65. 00	06500	457, 440	265, 768	41, 519	14, 199	0	0 65. 00
65. 01	06501	46, 695	27, 129	0	0	0	0 65. 01
66. 00	06600	289, 695	168, 310	0	0	0	0 66. 00
67. 00	06700	80, 989	47, 054	0	0	0	0 67. 00
68. 00	06800	3, 699	2, 149	0	0	0	0 68. 00
69. 00	06900	0	0	0	0	0	0 69. 00
71. 00	07100	47, 706	27, 717	0	0	0	0 71. 00
72. 00	07200	8, 309	4, 827	0	0	0	0 72. 00
73. 00	07300	442, 960	257, 355	0	0	0	0 73. 00
76. 00	03020	0	0	0	0	0	0 76. 00
76. 97	07697	95, 858	55, 692	7, 003	2, 395	0	0 76. 97
OUTPATIENT SERVICE COST CENTERS							
88. 00	08800	0	0	0	0	0	0 88. 00
89. 00	08900	0	0	0	0	0	0 89. 00
90. 00	09000	145, 754	84, 681	94, 943	32, 469	0	0 90. 00
91. 00	09100	1, 862, 069	1, 081, 842	190, 486	65, 144	0	0 91. 00
92. 00	09200	0	0	0	0	0	0 92. 00
OTHER REIMBURSABLE COST CENTERS							
95. 00	09500	1, 264, 086	734, 420	0	0	0	0 95. 00
99. 10	09910	0	0	0	0	0	0 99. 10
101. 00	10100	0	0	0	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS							
109. 00	10900	0	0	0	0	0	0 109. 00
110. 00	11000	0	0	0	0	0	0 110. 00
111. 00	11100	0	0	0	0	0	0 111. 00
113. 00	11300	0	0	0	0	0	0 113. 00
118. 00		18, 620, 441	6, 841, 193	1, 508, 031	503, 739	244, 320	118. 00
NONREIMBURSABLE COST CENTERS							
190. 00	19000	7, 159	4, 159	13, 106	4, 482	0	0 190. 00
192. 00	19200	0	0	0	0	0	0 192. 00
194. 00	07950	0	0	0	0	0	0 194. 00
194. 01	07951	0	0	0	0	0	0 194. 01
194. 02	07952	0	0	0	0	0	0 194. 02
200. 00		0	0	0	0	0	0 200. 00
201. 00		0	0	0	0	0	0 201. 00
202. 00		18, 627, 600	6, 845, 352	1, 521, 137	508, 221	244, 320	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	377,891					11.00
13.00	01300	5,224	354,613				13.00
14.00	01400	4,205	0	1,053,521			14.00
15.00	01500	0	0	114,332	786,309		15.00
16.00	01600	0	0	0	0	84,734	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	136,764	220,368	80,049	5,976	7,116	30.00
31.00	03100	0	0	0	0	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,712	38,206	191,478	18,143	6,576	50.00
53.00	05300	0	0	29,606	12,841	244	53.00
54.00	05400	28,220	0	56,885	7,387	18,658	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	415,289	555,280	18,651	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	0	0	62.00
65.00	06500	21,089	0	64,716	3,204	2,712	65.00
65.01	06501	0	0	0	0	727	65.01
66.00	06600	0	0	4,666	0	2,214	66.00
67.00	06700	0	0	0	0	113	67.00
68.00	06800	0	0	0	0	37	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	131	71.00
72.00	07200	0	0	0	0	78	72.00
73.00	07300	0	0	0	0	7,826	73.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	3,273	0	2,145	0	367	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	5,527	8,905	3,368	153	101	90.00
91.00	09100	54,077	87,134	38,773	4,831	9,979	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	95,800	0	52,214	178,494	9,204	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		377,891	354,613	1,053,521	786,309	84,734	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		377,891	354,613	1,053,521	786,309	84,734	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00560				5.02
7.00	00700				7.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,501,311	0	4,501,311	30.00
31.00	03100	0	0	0	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,501,982	0	1,501,982	50.00
53.00	05300	44,568	0	44,568	53.00
54.00	05400	2,261,954	0	2,261,954	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	1,676,659	0	1,676,659	60.00
60.01	06001	0	0	0	60.01
62.00	06200	0	0	0	62.00
65.00	06500	870,647	0	870,647	65.00
65.01	06501	74,551	0	74,551	65.01
66.00	06600	464,885	0	464,885	66.00
67.00	06700	128,156	0	128,156	67.00
68.00	06800	5,885	0	5,885	68.00
69.00	06900	0	0	0	69.00
71.00	07100	75,554	0	75,554	71.00
72.00	07200	13,214	0	13,214	72.00
73.00	07300	708,141	0	708,141	73.00
76.00	03020	0	0	0	76.00
76.97	07697	166,733	0	166,733	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	375,901	0	375,901	90.00
91.00	09100	3,394,335	0	3,394,335	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	2,334,218	0	2,334,218	95.00
99.10	09910	0	0	0	99.10
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
118.00		18,598,694	0	18,598,694	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	28,906	0	28,906	190.00
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		18,627,600	0	18,627,600	202.00

COST ALLOCATION STATISTICS

Provider CCN: 151302

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

Worksheet Non-CMS W

Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS SALARIES	4.00
5.01	ADMITTING	10	GROSS CHARGES	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.02
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	7	MEALS SERVED	10.00
11.00	CAFETERIA	8	FTE'S	11.00
13.00	NURSING ADMINISTRATION	9	FTE'S	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	10	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151302

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

Worksheet B
Part II
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		NEW BLDG & FIXT	NEW MVBLE EQUIP		
		0	2.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.01 00540	ADMINISTRATIVE	0	0	0	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	104,765	104,765	5.02
7.00 00700	OPERATION OF PLANT	0	430,563	430,563	7.00
9.00 00900	HOUSEKEEPING	0	19,155	19,155	9.00
10.00 01000	DIETARY	0	18,909	18,909	10.00
11.00 01100	CAFETERIA	0	50,114	50,114	11.00
13.00 01300	NURSING ADMINISTRATION	0	4,181	4,181	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	21,997	21,997	14.00
15.00 01500	PHARMACY	0	14,947	14,947	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	20,986	20,986	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	207,617	207,617	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	142,446	142,446	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	110,777	110,777	54.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	30,222	30,222	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	22,680	22,680	65.00
65.01 06501	SLEEP LAB	0	0	0	65.01
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03020	CARDIOLOGY	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	3,826	3,826	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000	CLINIC	0	51,863	51,863	90.00
91.00 09100	EMERGENCY	0	104,055	104,055	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	0	0	0	95.00
99.10 09910	CORF	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,359,103	1,359,103	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,159	7,159	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.01
194.02 07952	PHARMACY	0	0	0	194.02
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,366,262	1,366,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151302

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

Worksheet B
Part II
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	
		5.01	5.02	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540	0					5.01
5.02	00560	0	104,765				5.02
7.00	00700	0	8,555	439,118			7.00
9.00	00900	0	2,661	10,123	31,939		9.00
10.00	01000	0	1,113	9,993	744	30,759	10.00
11.00	01100	0	1,433	26,484	1,972	0	11.00
13.00	01300	0	1,907	2,209	164	0	13.00
14.00	01400	0	5,598	11,625	865	0	14.00
15.00	01500	0	3,573	7,899	588	0	15.00
16.00	01600	0	187	11,090	826	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	18,538	109,717	8,169	30,759	30.00
31.00	03100	0	0	0	0	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	4,915	75,278	5,604	0	50.00
53.00	05300	0	11	0	0	0	53.00
54.00	05400	0	10,566	58,541	4,358	0	54.00
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	3,449	15,971	1,189	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	0	0	62.00
65.00	06500	0	4,068	11,986	892	0	65.00
65.01	06501	0	415	0	0	0	65.01
66.00	06600	0	2,576	0	0	0	66.00
67.00	06700	0	720	0	0	0	67.00
68.00	06800	0	33	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	424	0	0	0	71.00
72.00	07200	0	74	0	0	0	72.00
73.00	07300	0	3,939	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	0	852	2,022	151	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	1,296	27,408	2,041	0	90.00
91.00	09100	0	16,558	54,989	4,094	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	11,240	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		0	104,701	435,335	31,657	30,759	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	64	3,783	282	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	104,765	439,118	31,939	30,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151302

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

Worksheet B
Part II
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	80,003					11.00
13.00	01300	1,106	9,567				13.00
14.00	01400	890	0	40,975			14.00
15.00	01500	0	0	4,447	31,454		15.00
16.00	01600	0	0	0	0	33,089	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28,954	5,945	3,113	239	2,779	30.00
31.00	03100	0	0	0	0	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,020	1,031	7,447	726	2,569	50.00
53.00	05300	0	0	1,151	514	95	53.00
54.00	05400	5,974	0	2,212	295	7,280	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	16,154	22,213	7,285	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	0	0	62.00
65.00	06500	4,465	0	2,517	128	1,059	65.00
65.01	06501	0	0	0	0	284	65.01
66.00	06600	0	0	181	0	865	66.00
67.00	06700	0	0	0	0	44	67.00
68.00	06800	0	0	0	0	15	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	51	71.00
72.00	07200	0	0	0	0	31	72.00
73.00	07300	0	0	0	0	3,057	73.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	693	0	83	0	143	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,170	240	131	6	39	90.00
91.00	09100	11,449	2,351	1,508	193	3,898	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	20,282	0	2,031	7,140	3,595	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		80,003	9,567	40,975	31,454	33,089	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		80,003	9,567	40,975	31,454	33,089	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 6/11/2013 2:37 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00560				5.02
7.00	00700				7.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	415,830	0	415,830	30.00
31.00	03100	0	0	0	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	245,036	0	245,036	50.00
53.00	05300	1,771	0	1,771	53.00
54.00	05400	200,003	0	200,003	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	96,483	0	96,483	60.00
60.01	06001	0	0	0	60.01
62.00	06200	0	0	0	62.00
65.00	06500	47,795	0	47,795	65.00
65.01	06501	699	0	699	65.01
66.00	06600	3,622	0	3,622	66.00
67.00	06700	764	0	764	67.00
68.00	06800	48	0	48	68.00
69.00	06900	0	0	0	69.00
71.00	07100	475	0	475	71.00
72.00	07200	105	0	105	72.00
73.00	07300	6,996	0	6,996	73.00
76.00	03020	0	0	0	76.00
76.97	07697	7,770	0	7,770	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	84,194	0	84,194	90.00
91.00	09100	199,095	0	199,095	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	44,288	0	44,288	95.00
99.10	09910	0	0	0	99.10
101.00	10100	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
118.00		1,354,974	0	1,354,974	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	11,288	0	11,288	190.00
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,366,262	0	1,366,262	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	50,000				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		0			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	7,347,190		4.00
5.01 00540	ADMITTING	0	0	368,688	43,322,456	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	3,834	0	361,230	0	-6,845,352 5.02
7.00 00700	OPERATION OF PLANT	15,757	0	145,105	0	7.00
9.00 00900	HOUSEKEEPING	701	0	145,571	0	9.00
10.00 01000	DIETARY	692	0	53,297	0	10.00
11.00 01100	CAFETERIA	1,834	0	87,222	0	11.00
13.00 01300	NURSING ADMINISTRATION	153	0	171,721	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	805	0	55,314	0	14.00
15.00 01500	PHARMACY	547	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	768	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,598	0	1,544,173	3,637,871	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,213	0	271,147	3,361,979	0 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	124,902	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,054	0	449,660	9,540,892	0 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	1,106	0	630,572	9,535,324	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	830	0	367,162	1,386,357	0 65.00
65.01 06501	SLEEP LAB	0	0	0	371,538	0 65.01
66.00 06600	PHYSICAL THERAPY	0	0	207,713	1,131,825	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	76,155	57,963	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	3,256	19,099	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	67,219	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	40,118	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,000,933	0 73.00
76.00 03020	CARDIOLOGY	0	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	140	0	75,698	187,661	0 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	1,898	0	81,855	51,463	0 90.00
91.00 09100	EMERGENCY	3,808	0	1,377,497	5,101,714	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	874,154	4,705,598	0 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	49,738	0	7,347,190	43,322,456	-6,845,352 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.01
194.02 07952	PHARMACY	0	0	0	0	0 194.02
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)	1,366,262	0	387,017	614,634	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.325240	0.000000	0.052676	0.014187	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1

Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00 Unit cost multiplier (Wkst. B, Part 11)			0.000000	0.000000	5A.02	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1

Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		5.02	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00540	ADMITTING					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	11,782,248				5.02
7.00	00700	OPERATION OF PLANT	962,143	30,409			7.00
9.00	00900	HOUSEKEEPING	299,278	701	29,708		9.00
10.00	01000	DIETARY	125,153	692	692	100	10.00
11.00	01100	CAFETERIA	161,149	1,834	1,834	0	17,435
13.00	01300	NURSING ADMINISTRATION	214,498	153	153	0	241
14.00	01400	CENTRAL SERVICES & SUPPLY	629,528	805	805	0	194
15.00	01500	PHARMACY	401,810	547	547	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	20,986	768	768	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,085,195	7,598	7,598	100	6,310
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	552,767	5,213	5,213	0	1,094
53.00	05300	ANESTHESIOLOGY	1,187	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,188,281	4,054	4,054	0	1,302
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	387,854	1,106	1,106	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	457,440	830	830	0	973
65.01	06501	SLEEP LAB	46,695	0	0	0	0
66.00	06600	PHYSICAL THERAPY	289,695	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	80,989	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	3,699	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,706	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,309	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	442,960	0	0	0	0
76.00	03020	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	95,858	140	140	0	151
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	145,754	1,898	1,898	0	255
91.00	09100	EMERGENCY	1,862,069	3,808	3,808	0	2,495
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,264,086	0	0	0	4,420
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,775,089	30,147	29,446	100	17,435
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,159	262	262	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.02	07952	PHARMACY	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,845,352	1,521,137	508,221	244,320	377,891
203.00		Unit cost multiplier (Wkst. B, Part I)	0.580989	50.022592	17.107210	2,443.200000	21.674276
204.00		Cost to be allocated (per Wkst. B, Part II)	104,765	439,118	31,939	30,759	80,003
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008892	14.440396	1.075098	307.590000	4.588644

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1

Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00540					5.01
5.02	00560					5.02
7.00	00700					7.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	10,154				13.00
14.00	01400	0	576,196			14.00
15.00	01500	0	62,531	61,845		15.00
16.00	01600	0	0	0	43,322,456	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	6,310	43,781	470	3,637,871	30.00
31.00	03100	0	0	0	0	31.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	1,094	104,724	1,427	3,361,979	50.00
53.00	05300	0	16,192	1,010	124,902	53.00
54.00	05400	0	31,112	581	9,540,892	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	227,131	43,674	9,535,324	60.00
60.01	06001	0	0	0	0	60.01
62.00	06200	0	0	0	0	62.00
65.00	06500	0	35,395	252	1,386,357	65.00
65.01	06501	0	0	0	371,538	65.01
66.00	06600	0	2,552	0	1,131,825	66.00
67.00	06700	0	0	0	57,963	67.00
68.00	06800	0	0	0	19,099	68.00
69.00	06900	0	0	0	0	69.00
71.00	07100	0	0	0	67,219	71.00
72.00	07200	0	0	0	40,118	72.00
73.00	07300	0	0	0	4,000,933	73.00
76.00	03020	0	0	0	0	76.00
76.97	07697	0	1,173	0	187,661	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
90.00	09000	255	1,842	12	51,463	90.00
91.00	09100	2,495	21,206	380	5,101,714	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	28,557	14,039	4,705,598	95.00
99.10	09910	0	0	0	0	99.10
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	0	0	0	0	109.00
110.00	11000	0	0	0	0	110.00
111.00	11100	0	0	0	0	111.00
113.00	11300					113.00
118.00		10,154	576,196	61,845	43,322,456	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		354,613	1,053,521	786,309	84,734	202.00
203.00		34.923478	1.828407	12.714189	0.001956	203.00
204.00		9,567	40,975	31,454	33,089	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1

Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.942190	0.071113	0.508594	0.000764		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151302

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

Worksheet C
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

			Title XVIII		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Dissallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,501,311		4,501,311	0	0	3,240,095	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	0	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,501,982		1,501,982	0	0	622,146	50.00
53.00	05300	ANESTHESIOLOGY	44,568		44,568	0	0	38,500	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,261,954		2,261,954	0	0	373,508	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	1,676,659		1,676,659	0	0	1,153,770	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	870,647	0	870,647	0	0	534,063	65.00
65.01	06501	SLEEP LAB	74,551	0	74,551	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	464,885	0	464,885	0	0	168,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,156	0	128,156	0	0	55,494	67.00
68.00	06800	SPEECH PATHOLOGY	5,885	0	5,885	0	0	18,775	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,554		75,554	0	0	31,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,214		13,214	0	0	2,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	708,141		708,141	0	0	1,801,014	73.00
76.00	03020	CARDIOLOGY	0		0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	166,733		166,733	0	0	3,411	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	375,901		375,901	0	0	0	90.00
91.00	09100	EMERGENCY	3,394,335		3,394,335	0	0	83,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	397,294		397,294	0	0	10,731	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	2,334,218		2,334,218	0	0	17,982	95.00
99.10	09910	CORF	0		0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	0	113.00
200.00		Subtotal (see instructions)	18,995,988	0	18,995,988	0	0	8,155,853	200.00
201.00		Less Observation Beds	397,294		397,294	0	0	0	201.00
202.00		Total (see instructions)	18,598,694	0	18,598,694	0	0	8,155,853	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151302

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

Worksheet C
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

			Title XVIII		Hospital		Cost		
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00				9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		3,240,095					30.00
31.00	03100	INTENSIVE CARE UNIT		0					31.00
41.00	04100	SUBPROVIDER - IRF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		0					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,739,834	3,361,980	0.446755	0.000000	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	86,402	124,902	0.356824	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,167,384	9,540,892	0.237080	0.000000	0.000000		54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00
60.00	06000	LABORATORY	8,381,554	9,535,324	0.175837	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	852,294	1,386,357	0.628011	0.000000	0.000000		65.00
65.01	06501	SLEEP LAB	371,538	371,538	0.200655	0.000000	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	963,731	1,131,825	0.410739	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,469	57,963	2.210997	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	324	19,099	0.308131	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,552	67,218	1.124014	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,504	40,118	0.329378	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,199,919	4,000,933	0.176994	0.000000	0.000000		73.00
76.00	03020	CARDIOLOGY	0	0	0.000000	0.000000	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	184,249	187,660	0.888484	0.000000	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90.00	09000	CLINIC	51,463	51,463	7.304296	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	5,017,724	5,101,714	0.665332	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	387,045	397,776	0.998788	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	4,687,616	4,705,598	0.496051	0.000000	0.000000		95.00
99.10	09910	CORF	0	0					99.10
101.00	10100	HOME HEALTH AGENCY	0	0					101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0	0					110.00
111.00	11100	ISLET ACQUISITION	0	0					111.00
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	35,166,602	43,322,455					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	35,166,602	43,322,455					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 6/11/2013 2:37 pm		
			Title XIX	Hospital	Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges	
			Total Costs	RCE Dissallowance	Total Costs	Inpatient	
	1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		4,501,311	0	0	3,240,095	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	0	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	0	42.00
43.00	04300 NURSERY		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,501,982	0	0	622,146	50.00
53.00	05300 ANESTHESIOLOGY		44,568	0	0	38,500	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,261,954	0	0	373,508	54.00
57.00	05700 CT SCAN		0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	0	59.00
60.00	06000 LABORATORY		1,676,659	0	0	1,153,770	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	870,647	0	0	534,063	65.00
65.01	06501 SLEEP LAB	0	74,551	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	464,885	0	0	168,094	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	128,156	0	0	55,494	67.00
68.00	06800 SPEECH PATHOLOGY	0	5,885	0	0	18,775	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		75,554	0	0	31,666	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		13,214	0	0	2,614	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		708,141	0	0	1,801,014	73.00
76.00	03020 RADIOLOGY		0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION		166,733	0	0	3,411	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
90.00	09000 CLINIC		375,901	0	0	0	90.00
91.00	09100 EMERGENCY		3,394,335	0	0	83,990	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		397,294	0	0	10,731	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		2,334,218	0	0	17,982	95.00
99.10	09910 CORF		0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION		0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE		0	0	0	0	113.00
200.00	Subtotal (see instructions)		18,995,988	0	0	8,155,853	200.00
201.00	Less Observation Beds		397,294	0	0	0	201.00
202.00	Total (see instructions)		18,598,694	0	0	8,155,853	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151302

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

Worksheet C
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

			Title XIX		Hospital		Cost		
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00				9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		3,240,095					30.00
31.00	03100	INTENSIVE CARE UNIT		0					31.00
41.00	04100	SUBPROVIDER - IRF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		0					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,739,834	3,361,980	0.446755	0.000000	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	86,402	124,902	0.356824	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,167,384	9,540,892	0.237080	0.000000	0.000000		54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00
60.00	06000	LABORATORY	8,381,554	9,535,324	0.175837	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	852,294	1,386,357	0.628011	0.000000	0.000000		65.00
65.01	06501	SLEEP LAB	371,538	371,538	0.200655	0.000000	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	963,731	1,131,825	0.410739	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,469	57,963	2.210997	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	324	19,099	0.308131	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,552	67,218	1.124014	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,504	40,118	0.329378	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,199,919	4,000,933	0.176994	0.000000	0.000000		73.00
76.00	03020	CARDIOLOGY	0	0	0.000000	0.000000	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	184,249	187,660	0.888484	0.000000	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0.000000		89.00
90.00	09000	CLINIC	51,463	51,463	7.304296	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	5,017,724	5,101,714	0.665332	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	387,045	397,776	0.998788	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	4,687,616	4,705,598	0.496051	0.000000	0.000000		95.00
99.10	09910	CORF	0	0					99.10
101.00	10100	HOME HEALTH AGENCY	0	0					101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0	0					110.00
111.00	11100	ISLET ACQUISITION	0	0					111.00
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	35,166,602	43,322,455					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	35,166,602	43,322,455					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 6/11/2013 2:37 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	245,036	3,361,980	0.072884	320,087	23,329	50.00
53.00	05300 ANESTHESIOLOGY	1,771	124,902	0.014179	21,336	303	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	200,003	9,540,892	0.020963	150,005	3,145	54.00
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	96,483	9,535,324	0.010118	552,100	5,586	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	47,795	1,386,357	0.034475	242,759	8,369	65.00
65.01	06501 SLEEP LAB	699	371,538	0.001881	0	0	65.01
66.00	06600 PHYSICAL THERAPY	3,622	1,131,825	0.003200	23,700	76	66.00
67.00	06700 OCCUPATIONAL THERAPY	764	57,963	0.013181	3,400	45	67.00
68.00	06800 SPEECH PATHOLOGY	48	19,099	0.002513	7,091	18	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	475	67,218	0.007067	20,487	145	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	105	40,118	0.002617	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,996	4,000,933	0.001749	773,069	1,352	73.00
76.00	03020 RADIOLOGY	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	7,770	187,660	0.041405	2,151	89	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	84,194	51,463	1.636010	0	0	90.00
91.00	09100 EMERGENCY	199,095	5,101,714	0.039025	14,030	548	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	397,776	0.000000	2,519	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	894,856	35,376,762		2,132,734	43,005	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
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
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 6/11/2013 2:37 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	3,361,980	0.000000	0.000000	320,087	50.00
53.00	05300 ANESTHESIOLOGY	0	124,902	0.000000	0.000000	21,336	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	9,540,892	0.000000	0.000000	150,005	54.00
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	9,535,324	0.000000	0.000000	552,100	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,386,357	0.000000	0.000000	242,759	65.00
65.01	06501 SLEEP LAB	0	371,538	0.000000	0.000000	0	65.01
66.00	06600 PHYSICAL THERAPY	0	1,131,825	0.000000	0.000000	23,700	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	57,963	0.000000	0.000000	3,400	67.00
68.00	06800 SPEECH PATHOLOGY	0	19,099	0.000000	0.000000	7,091	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,218	0.000000	0.000000	20,487	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	40,118	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,000,933	0.000000	0.000000	773,069	73.00
76.00	03020 RADIOLOGY	0	0	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	187,660	0.000000	0.000000	2,151	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	51,463	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	5,101,714	0.000000	0.000000	14,030	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	397,776	0.000000	0.000000	2,519	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	35,376,762			2,132,734	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 6/11/2013 2:37 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges	Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00			
			Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	4.00			
				5.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.446755	0	701,416	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.356824	0	12,163	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237080	0	2,892,661	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.175837	0	3,046,190	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.628011	0	423,700	0	0	65.00
65.01	06501 SLEEP LAB	0.200655	0	150,683	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.410739	0	342,139	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	2.210997	0	1,512	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.308131	0	205	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.124014	0	6,995	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.329378	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.176994	0	637,887	5,950	0	73.00
76.00	03020 RADIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.888484	0	86,006	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	7.304296	0	22,435	0	0	90.00
91.00	09100 EMERGENCY	0.665332	0	1,478,568	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.998788	0	184,252	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.496051		0			95.00
200.00	Subtotal (see instructions)		0	9,986,812	5,950	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	9,986,812	5,950	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 6/11/2013 2:37 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	313,361	0	50.00
53.00	05300 ANESTHESIOLOGY	4,340	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	685,792	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	535,633	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	266,088	0	65.00
65.01	06501 SLEEP LAB	30,235	0	65.01
66.00	06600 PHYSICAL THERAPY	140,530	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,343	0	67.00
68.00	06800 SPEECH PATHOLOGY	63	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,862	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	112,902	1,053	73.00
76.00	03020 RADIOLOGY	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	76,415	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	163,872	0	90.00
91.00	09100 EMERGENCY	983,739	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	184,029	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	3,508,204	1,053	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	3,508,204	1,053	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 6/11/2013 2:37 pm
		Component CCN: 15Z302	Title XVIII	Swing Beds - SNF Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.446755	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0.356824	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.237080	0	0	0	0 54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.175837	0	0	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	0.628011	0	0	0	0 65.00
65.01 06501 SLEEP LAB	0.200655	0	0	0	0 65.01
66.00 06600 PHYSICAL THERAPY	0.410739	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	2.210997	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.308131	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.124014	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.329378	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.176994	0	0	0	0 73.00
76.00 03020 RADIOLOGY	0.000000	0	0	0	0 76.00
76.97 07697 CARDIAC REHABILITATION	0.888484	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	7.304296	0	0	0	0 90.00
91.00 09100 EMERGENCY	0.665332	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.998788	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.496051		0		0 95.00
200.00 Subtotal (see instructions)		0	0	0	0 200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 6/11/2013 2:37 pm
		Component CCN: 15Z302	Title XVIII	Swing Beds - SNF
				Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII		Date/Time Prepared: 6/11/2013 2:37 pm
		Hospital		Cost
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)		3,331	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,861	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,567	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,470	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)		1,216	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)		1,248	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,501,311	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)		1,986,470	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,514,841	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,361,470	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,361,470	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.064947	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,507.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,514,841	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,351.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,643,229	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)		1,643,229	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 6/11/2013 2:37 pm	
Cost Center Description			Title XVIII		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				628,767	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,271,996	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)				1,686,472	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)				1,686,472	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)				294	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,351.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				397,294	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151302

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

Worksheet D-1

Date/Time Prepared:
6/11/2013 2:37 pm

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 6/11/2013 2:37 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)		3,331	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,861	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,567	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,470	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)		97	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,501,311	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)		1,986,470	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,514,841	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,514,841	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,351.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		131,080	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)		131,080	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 6/11/2013 2:37 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				76,680	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				207,760	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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				294	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,351.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				397,294	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151302

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

Worksheet D-1
Date/Time Prepared:
6/11/2013 2:37 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 6/11/2013 2:37 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		1,748,315	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.446755	320,087	50.00
53.00	05300	ANESTHESIOLOGY	0.356824	21,336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237080	150,005	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.175837	552,100	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.628011	242,759	65.00
65.01	06501	SLEEP LAB	0.200655	0	65.01
66.00	06600	PHYSICAL THERAPY	0.410739	23,700	66.00
67.00	06700	OCCUPATIONAL THERAPY	2.210997	3,400	67.00
68.00	06800	SPEECH PATHOLOGY	0.308131	7,091	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.124014	20,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.329378	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176994	773,069	73.00
76.00	03020	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.888484	2,151	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	7.304296	0	90.00
91.00	09100	EMERGENCY	0.665332	14,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.998788	2,519	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,132,734	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		2,132,734	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15Z302		Date/Time Prepared: 6/11/2013 2:37 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.446755	5,052	50.00
53.00	05300	ANESTHESIOLOGY	0.356824	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237080	66,317	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.175837	295,997	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.628011	199,047	65.00
65.01	06501	SLEEP LAB	0.200655	0	65.01
66.00	06600	PHYSICAL THERAPY	0.410739	125,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	2.210997	44,340	67.00
68.00	06800	SPEECH PATHOLOGY	0.308131	8,626	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.124014	1,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.329378	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176994	605,671	73.00
76.00	03020	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.888484	413	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	7.304296	0	90.00
91.00	09100	EMERGENCY	0.665332	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.998788	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,352,388	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,352,388	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 6/11/2013 2:37 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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		148,084	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.446755	53,359	50.00
53.00	05300	ANESTHESIOLOGY	0.356824	2,326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237080	33,415	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.175837	74,889	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.628011	25,963	65.00
65.01	06501	SLEEP LAB	0.200655	0	65.01
66.00	06600	PHYSICAL THERAPY	0.410739	987	66.00
67.00	06700	OCCUPATIONAL THERAPY	2.210997	224	67.00
68.00	06800	SPEECH PATHOLOGY	0.308131	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.124014	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.329378	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176994	0	73.00
76.00	03020	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.888484	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	7.304296	0	90.00
91.00	09100	EMERGENCY	0.665332	20,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.998788	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		211,780	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		211,780	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15Z302		Date/Time Prepared: 6/11/2013 2:37 pm	
		Title XIX	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.446755	0	50.00
53.00	05300	ANESTHESIOLOGY	0.356824	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237080	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.175837	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.628011	0	65.00
65.01	06501	SLEEP LAB	0.200655	0	65.01
66.00	06600	PHYSICAL THERAPY	0.410739	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2.210997	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.308131	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.124014	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.329378	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176994	0	73.00
76.00	03020	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.888484	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	7.304296	0	90.00
91.00	09100	EMERGENCY	0.665332	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.998788	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 6/11/2013 2:37 pm
		Title XVII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,509,257	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,509,257	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)		3,544,350	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		17,480	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,467,478	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)		2,059,392	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)		2,059,392	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,059,392	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)		146,438	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		146,438	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		146,438	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,205,830	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,205,830	40.00
41.00	Interim payments		2,278,557	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)		-72,727	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151302

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

Worksheet E-1
Part I
Date/Time Prepared:
6/11/2013 2:37 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,774,380		2,038,557	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	08/28/2012	77,600	08/28/2012	240,000	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)		77,600		240,000	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,851,980		2,278,557	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		177,534		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		72,727	6.02	
7.00	Total Medicare program liability (see instructions)		2,029,514		2,205,830	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151302

Period:

Worksheet E-1

Component CCN: 15Z302

From 01/01/2012

Part I

To 12/31/2012

Date/Time Prepared:

6/11/2013 2:37 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,848,657		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/28/2012	65,800		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)		65,800		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)		1,914,457		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		225,219		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,139,676		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151302

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

Worksheet E-1
Part II
Date/Time Prepared:
6/11/2013 2:37 pm

		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			606	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,216	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			16	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,567	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			43,322,455	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			495,160	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			488,335	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			488,335	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment			0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151302

Period:

Worksheet E-2

Component CCN: 15Z302

From 01/01/2012

Date/Time Prepared:

To 12/31/2012

6/11/2013 2:37 pm

		Title XVIII		Swing Beds - SNF	
		Cost			
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,703,337	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	460,778	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	1,248	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,164,115	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	2,164,115	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	2,164,115	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	25,288	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,138,827	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Reimbursable bad debts (see instructions)	849	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	849	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,139,676	0	19.00	
20.00	Interim payments	1,914,457	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	225,219	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

		Provider CCN: 151302	Period: From 01/01/2012	Worksheet E-2
		Component CCN: 15Z302	To 12/31/2012	Date/Time Prepared: 6/11/2013 2:37 pm
		Title XIX	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Reimbursable bad debts (see instructions)		0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0	19.00
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 6/11/2013 2:37 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,271,996 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,271,996 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,294,716 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,294,716 19.00
20.00	Deductibles (exclude professional component)			270,504 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,024,212 22.00
23.00	Coinsurance			2,312 23.00
24.00	Subtotal (line 22 minus line 23)			2,021,900 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			7,614 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			7,614 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,302 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,029,514 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,029,514 30.00
31.00	Interim payments			1,851,980 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			177,534 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			437,956 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151302	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 6/11/2013 2:37 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		207,760		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)		207,760	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		207,760	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		211,780	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		211,780	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		211,780	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,020	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		207,760	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		207,760	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		207,760	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		207,760	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		207,760	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		207,760	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus 41)		207,760	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0		43.00

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

Provider CCN: 151302

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

Worksheet G

Date/Time Prepared:
6/11/2013 2:37 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	1,115,735	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	2,313,371	0	0	0	4.00
5.00	Other receivable	248,634	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	173,225	0	0	0	7.00
8.00	Prepaid expenses	88,170	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,939,135	0	0	0	11.00
FIXED ASSETS						
12.00	Land	190,324	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	14,942,522	0	0	0	15.00
16.00	Accumulated depreciation	-5,559,575	0	0	0	16.00
17.00	Leasehold improvements	275,335	0	0	0	17.00
18.00	Accumulated depreciation	-178,702	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	531,159	0	0	0	21.00
22.00	Accumulated depreciation	-437,896	0	0	0	22.00
23.00	Major movable equipment	5,154,285	0	0	0	23.00
24.00	Accumulated depreciation	-3,940,407	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)	10,977,045	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	55,773	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	55,773	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,971,953	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,170,991	0	0	0	37.00
38.00	Salaries, wages, and fees payable	787,405	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	2,115,514	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,073,910	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	39,562	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,562	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,113,472	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,858,481				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)	10,858,481	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,971,953	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151302

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

Worksheet G-1

Date/Time Prepared:
6/11/2013 2:37 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,056,869		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-198,388				2.00
3.00	Total (sum of line 1 and line 2)		10,858,481		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,858,481		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,858,481		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151302

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
6/11/2013 2:37 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,361,470		2,361,470	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	878,625		878,625	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)	3,240,095		3,240,095	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	3,240,095		3,240,095	17.00
18.00	Ancillary services	4,897,777	30,427,525	35,325,302	18.00
19.00	Outpatient services	0	51,463	51,463	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY	0	0	0	22.00
23.00	AMBULANCE SERVICES	17,982	4,687,616	4,705,598	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)	8,155,854	35,166,604	43,322,458	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,576,583		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	931,879			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)		931,879		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,644,704		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151302

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

Worksheet G-3

Date/Time Prepared:
6/11/2013 2:37 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,322,458	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,419,419	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,903,039	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,644,704	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,741,665	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-67,838	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	ER PHYSICIAN REVENUE	1,611,115	24.00
25.00	Total other income (sum of lines 6-24)	1,543,277	25.00
26.00	Total (line 5 plus line 25)	-198,388	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)	-198,388	29.00