

Pinnacle Hospital, LLC

Medicare Cost Report

Fiscal Year Ended 12.31.2012

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: 150166
 Period: From 01/01/2012 To 12/31/2012
 Worksheet S Parts I-III
 Date/Time Prepared: 5/30/2013 3:14 pm

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Date: 5/30/2013 Time: 3:14 pm

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MI SREPRESENTATION 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 PINNACLE HOSPITAL (150166) 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.

Encryption Information

ECR: Date: 5/30/2013 Time: 3:14 pm
 59N6Ftq7cl yvl mwI 8MtnSRI vkSqJLO
 ri nVG0BwrZhc71W0wrRDBJycw90UF:
 5FuFOELhm30hgmDJ
 PI: Date: 5/30/2013 Time: 3:14 pm
 cbUBmsi xGHj . aL5ZY6OuLcz0uylXg0
 EBy: IOEzHCtak. yj 3rGI BmCy5PETXm
 uND: OY1hMMOchw4V

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	0	138	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	0	138	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150166		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 3:13 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 9301 CONNECTICUT DRIVE		PO Box:						1.00		
2.00	City: CROWN POINT		State: IN		Zip Code: 46307		County: LAKE		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	V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		PINNACLE HOSPITAL	150166	23844	1	08/01/2007	N	P	N	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
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)					5			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			22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0		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.					1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00		

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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)	N	0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1 / (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

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

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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		N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					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)					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
				1.00	2.00	3.00
				Respiratory		4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.00	List amounts of malpractice premiums and paid losses:	103,165	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		
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		
142.00	Street:	PO Box:			
143.00	City:	State:	Zip Code:		
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150166			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 3:13 pm		
								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 3:13 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	A	07/30/2013	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.	Y			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.			N	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	04/30/2013	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: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 3:13 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N			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?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
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.	KARRIE		PENCE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	816-751-1831		KARRIE.PENCE@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 3:13 pm
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		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)	04/30/2013	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.	SUPERVISOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150166

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2013 3:13 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / 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	18	6,588	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		18	6,588	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		18	6,588	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		18				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P 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	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,244	0	2,601			1.00
2.00 HMO	0	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	0	0	0			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)	1,244	0	2,601			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)	1,244	0	2,601	0.00	117.45	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part I Date/Time Prepared: 5/30/2013 3:13 pm
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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	117.45	27.00
28.00	Observation Bed Days		0	308			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title VIII	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	336	0	731	1.00
2.00	HMO			0			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	336	0	731	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150166		Period: From 01/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/30/2013 3:13 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	7,374,240	-1,320,360	6,053,880	244,291.00	24.78	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,346,952	-761,845	585,107	29,481.00	19.85	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		549,950	0	549,950	8,757.00	62.80	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		1,927,763	0	1,927,763			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		242,123	0	242,123			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	97,594	-18,833	78,761	2,080.00	37.87	26.00
27.00	Administrative & General	5.00	1,841,846	-152,344	1,689,502	47,488.00	35.58	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	34,441	-2,749	31,692	1,287.00	24.62	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	53,584	16,936	70,520	5,892.00	11.97	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	123,157	-24,319	98,838	7,533.00	13.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	192,284	-28,079	164,205	10,153.00	16.17	39.00
40.00	Pharmacy	15.00	210,835	1,997	212,832	3,571.00	59.60	40.00

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150166

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2013 3:13 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 143,575	-34,147	109,428	7,082.00	15.45	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150166

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2013 3:13 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hours Rel ated to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	7,374,240	-1,320,360	6,053,880	244,291.00	24.78	1.00
2.00	Excluded area salaries (see instructions)	1,346,952	-761,845	585,107	29,481.00	19.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)	6,027,288	-558,515	5,468,773	214,810.00	25.46	3.00
4.00	Subtotal other wages & related costs (see inst.)	549,950	0	549,950	8,757.00	62.80	4.00
5.00	Subtotal wage-related costs (see inst.)	1,927,763	0	1,927,763	0.00	35.25	5.00
6.00	Total (sum of lines 3 thru 5)	8,505,001	-558,515	7,946,486	223,567.00	35.54	6.00
7.00	Total overhead cost (see instructions)	2,697,316	-241,538	2,455,778	85,086.00	28.86	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2013 3:13 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	837,320	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	62,415	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	15,339	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	51,417	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	608,636	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	594,760	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,169,887	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150166

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

Worksheet S-3
Part V
Date/Time Prepared:
5/30/2013 3:13 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	667,050	0	1.00
2.00	Hospital	667,050	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/30/2013 3:13 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)		0.314611		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		0		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		0		6.00	
7.00	Medicaid cost (line 1 times line 6)		0		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)		0		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)		0		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				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	41,490	0	41,490	20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	13,053	0	13,053	21.00	
22.00	Partial payment by patients approved for charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	13,053	0	13,053	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			508,210	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)			0	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			508,210	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			159,888	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			172,941	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			172,941	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150166

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

Worksheet A
Date/Time Prepared:
5/30/2013 3:13 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		314,240		314,240	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,001,455	684,686	1,686,141	2.00
4.00	00400	EMPLOYEE BENEFITS	97,594	658,932	756,526	756,526	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,841,846	9,945,835	11,787,681	-676,060	11,111,621
7.00	00700	OPERATION OF PLANT	34,441	517,185	551,626	0	551,626
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	53,584	63,067	116,651	0	116,651
10.00	01000	DIETARY	123,157	106,842	229,999	0	229,999
11.00	01100	CAFETERIA	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	192,284	208,628	400,912	0	400,912
15.00	01500	PHARMACY	210,835	14,617	225,452	0	225,452
16.00	01600	MEDICAL RECORDS & LIBRARY	143,575	78,268	221,843	0	221,843
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,171,520	6,268	1,177,788	0	1,177,788
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,145,287	28,438	1,173,725	-7,350	1,166,375
53.00	05300	ANESTHESIOLOGY	0	340,629	340,629	0	340,629
54.00	05400	RADIOLOGY-DIAGNOSTIC	516,141	-12,564	503,577	-1,276	502,301
60.00	06000	LABORATORY	87,776	330,644	418,420	0	418,420
65.00	06500	RESPIRATORY THERAPY	300,725	4,506	305,231	0	305,231
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,147,858	1,147,858	0	1,147,858
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,276,139	4,276,139	0	4,276,139
73.00	07300	DRUGS CHARGED TO PATIENTS	0	328,328	328,328	0	328,328
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	URGENT CARE	108,523	4,872	113,395	0	113,395
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
114.00	11400	UTILIZATION REVIEW - SNF	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,027,288	19,364,187	25,391,475	0	25,391,475
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,346,952	1,051,327	2,398,279	0	2,398,279
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118-199)	7,374,240	20,415,514	27,789,754	0	27,789,754
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	1,903,326	2,217,566			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-110,763	1,575,378			2.00
4.00	00400	EMPLOYEE BENEFITS	-5,795	750,731			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,144,023	7,967,598			5.00
7.00	00700	OPERATION OF PLANT	-4,191	547,435			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	0	116,651			9.00
10.00	01000	DIETARY	-909	229,090			10.00
11.00	01100	CAFETERIA	0	0			11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	400,912			14.00
15.00	01500	PHARMACY	0	225,452			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,831	225,674			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	-1,894	1,175,894			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	-264	1,166,111			50.00
53.00	05300	ANESTHESIOLOGY	-339,518	1,111			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-75	502,226			54.00
60.00	06000	LABORATORY	0	418,420			60.00
65.00	06500	RESPIRATORY THERAPY	0	305,231			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,147,858			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,276,139			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	328,328			73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	URGENT CARE	-4,119	109,276			90.01

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150166

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

Worksheet A
Date/Time Prepared:
5/30/2013 3:13 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
114.00	11400 UTILIZATION REVIEW - SNF	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,704,394	23,687,081	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	2,398,279	192.00
194.00	07950 INDIANA BREAST CENTER	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,704,394	26,085,360	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BENEFIT EXPENSE					
1.00	EMPLOYEE BENEFITS	4.00	0	18,833	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	152,344	2.00
3.00	OPERATION OF PLANT	7.00	0	2,749	3.00
4.00	DIETARY	10.00	0	24,319	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	28,079	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	34,147	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	209,793	7.00
8.00	OPERATING ROOM	50.00	0	22,964	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,469	9.00
10.00	LABORATORY	60.00	0	4,205	10.00
11.00	URGENT CARE	90.01	0	49,760	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	761,845	12.00
13.00	HOUSEKEEPING	9.00	16,936	0	13.00
14.00	PHARMACY	15.00	1,997	0	14.00
15.00	RESPIRATORY THERAPY	65.00	3,214	0	15.00
TOTALS			22,147	1,342,507	
B - CAPITAL INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	113,329	1.00
TOTALS			0	113,329	
C - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	571,357	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	571,357	
500.00	Grand Total: Increases		22,147	2,027,193	500.00

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - BENEFIT EXPENSE						
1.00	EMPLOYEE BENEFITS	4.00	18,833	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	152,344	0	0	2.00
3.00	OPERATION OF PLANT	7.00	2,749	0	0	3.00
4.00	DIETARY	10.00	24,319	0	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	28,079	0	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	34,147	0	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	209,793	0	0	7.00
8.00	OPERATING ROOM	50.00	22,964	0	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	33,469	0	0	9.00
10.00	LABORATORY	60.00	4,205	0	0	10.00
11.00	URGENT CARE	90.01	49,760	0	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	761,845	0	0	12.00
13.00	HOUSEKEEPING	9.00	0	16,936	0	13.00
14.00	PHARMACY	15.00	0	1,997	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	3,214	0	15.00
TOTALS			1,342,507	22,147		
B - CAPITAL INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,329	11	1.00
TOTALS			0	113,329		
C - RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	562,731	10	1.00
2.00	OPERATING ROOM	50.00	0	7,350	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,276	0	3.00
TOTALS			0	571,357		
500.00	Grand Total: Decreases		1,342,507	706,833		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150166

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

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2013 3:13 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	25,000	0	0	0	0	1.00
2.00	Land Improvements	211,203	0	0	0	0	2.00
3.00	Buildings and Fixtures	535,051	33,390	0	33,390	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	129,683	0	0	0	0	5.00
6.00	Movable Equipment	10,072,658	2,626,001	0	2,626,001	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,973,595	2,659,391	0	2,659,391	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,973,595	2,659,391	0	2,659,391	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	25,000	0				1.00
2.00	Land Improvements	211,203	0				2.00
3.00	Buildings and Fixtures	568,441	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	129,683	0				5.00
6.00	Movable Equipment	12,698,659	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	13,632,986	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	13,632,986	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150166

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

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2013 3:13 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	0	0	0	0	314,240	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,001,455	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,001,455	0	0	0	314,240	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	314,240				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,001,455				2.00
3.00	Total (sum of lines 1-2)	0	1,315,695				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150166

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

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2013 3:13 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	934,327	0	934,327	0.068534	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	12,698,659	0	12,698,659	0.931466	0	2.00
3.00	Total (sum of lines 1-2)	13,632,986	0	13,632,986	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	1,903,326	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	890,692	571,357	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,794,018	571,357	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	0	314,240	0	2,217,566	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	113,329	0	0	0	1,575,378	2.00
3.00	Total (sum of lines 1-2)	113,329	0	314,240	0	3,792,944	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
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)	B	-2,198	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00 Investment income - other (chapter 2)	B	-5,265	ADMINISTRATIVE & GENERAL	5.00	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)	B	-16,322	ADMINISTRATIVE & GENERAL	5.00	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)	A	-3,954	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-2,435	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-687,018			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	103,421			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	3,955	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	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		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	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			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant				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		SPEECH PATHOLOGY	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 MISC REVENUE	B	-5,521	EMPLOYEE BENEFITS		4.00	0	33.00
33.01 FACILITY FEES	B	-27,590	ADMINISTRATIVE & GENERAL		5.00	0	33.01
33.02 MISC REVENUE	B	-85,133	ADMINISTRATIVE & GENERAL		5.00	0	33.02
33.03 DEPRECIATION EXPENSE	A	-47,908	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	33.03
33.04 DEPRECIATION EXPENSE	A	-60,657	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	33.04
33.05 MARKETING-EB	A	-274	EMPLOYEE BENEFITS		4.00	0	33.05
33.06 MARKETING - A&G	A	-347,988	ADMINISTRATIVE & GENERAL		5.00	0	33.06
33.07 MARKETING-PLANT	A	-1,696	OPERATION OF PLANT		7.00	0	33.07
33.08 MARKETING-DIETARY	A	-909	DIETARY		10.00	0	33.08
33.09 MARKETING ADULTS & PEDS	A	-1,894	ADULTS & PEDIATRICS		30.00	0	33.09
33.10 MARKETING-RADIOLOGY	A	-264	OPERATING ROOM		50.00	0	33.10
33.11 MARKETING-URGENT CARE	A	-75	RADIOLOGY-DIAGNOSTIC		54.00	0	33.11
33.12 MARKETING-CLINIC	A	-4,119	URGENT CARE		90.01	0	33.12
33.13 BAD DEBT EXPENSE	A	-508,009	ADMINISTRATIVE & GENERAL		5.00	0	33.13
33.14 CHARITABLE CONTRIBUTIONS	A	-700	ADMINISTRATIVE & GENERAL		5.00	0	33.14
33.15 REBATES	B	-124	MEDICAL RECORDS & LIBRARY		16.00	0	33.15
33.16 MEDICAL RECORDS	B	-1,657	ADMINISTRATIVE & GENERAL		5.00	0	33.16
33.17 MEDICAL RECORDS	B	-60	OPERATION OF PLANT		7.00	0	33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,704,394					50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 150166
 Period: From 01/01/2012 To 12/31/2012
 Worksheet A-8-1
 Date/Time Prepared: 5/30/2013 3:13 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	5.00	ADMINISTRATIVE & GENERAL	95	1,800,000
2.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	1,903,326	0
3.00	0.00		0	0
4.00	0.00		0	0
5.00	0		1,903,421	1,800,000

* 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	G	MRA	100.00	PINNACLE HOSPITAL	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:	FINANCIAL				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: 150166

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

Worksheet A-8-1

Date/Time Prepared:
5/30/2013 3:13 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	-1,799,905	0		1.00
2.00	1,903,326	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	103,421			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	HEALTH CARE		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: 150166

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2013 3:13 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	339,518	339,518	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	347,500	347,500	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			687,018	687,018	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	339,518		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	347,500		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	687,018		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150166

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 3:13 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,217,566	2,217,566			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,575,378		1,575,378		2.00
4.00 00400	EMPLOYEE BENEFITS	750,731	0	0	750,731	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,967,598	402,917	286,236	212,274	8,869,025
7.00 00700	OPERATION OF PLANT	547,435	241,624	171,652	3,982	964,693
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,831	8,405	0	20,236
9.00 00900	HOUSEKEEPING	116,651	0	0	8,860	125,511
10.00 01000	DIETARY	229,090	29,225	20,762	12,418	291,495
11.00 01100	CAFETERIA	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	400,912	0	0	20,631	421,543
15.00 01500	PHARMACY	225,452	14,872	10,565	26,741	277,630
16.00 01600	MEDICAL RECORDS & LIBRARY	225,674	0	0	13,749	239,423
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,175,894	457,436	324,966	120,834	2,079,130
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,166,111	768,859	546,204	141,012	2,622,186
53.00 05300	ANESTHESIOLOGY	1,111	0	0	0	1,111
54.00 05400	RADIOLOGY-DIAGNOSTIC	502,226	184,584	131,130	60,644	878,584
60.00 06000	LABORATORY	418,420	16,244	11,540	10,500	456,704
65.00 06500	RESPIRATORY THERAPY	305,231	2,893	2,055	38,188	348,367
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,147,858	0	0	0	1,147,858
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	4,276,139	0	0	0	4,276,139
73.00 07300	DRUGS CHARGED TO PATIENTS	328,328	0	0	0	328,328
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	URGENT CARE	109,276	87,081	61,863	7,383	265,603
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,687,081	2,217,566	1,575,378	677,216	23,613,566
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,398,279	0	0	73,515	2,471,794
194.00 07950	INDIANA BREAST CENTER	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	26,085,360	2,217,566	1,575,378	750,731	26,085,360
Cost Center Description						
	ADMINISTRATIVE & GENERAL		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,869,025				5.00
7.00 00700	OPERATION OF PLANT	496,964	1,461,657			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	10,425	10,993	41,654		8.00
9.00 00900	HOUSEKEEPING	64,657	0	0	190,168	9.00
10.00 01000	DIETARY	150,164	27,156	0	3,560	472,375
11.00 01100	CAFETERIA	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	217,159	0	0	0	0
15.00 01500	PHARMACY	143,022	13,819	0	1,812	0
16.00 01600	MEDICAL RECORDS & LIBRARY	123,339	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,071,068	425,050	41,654	55,720	472,375
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,350,824	714,425	0	93,654	0
53.00 05300	ANESTHESIOLOGY	572	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	452,604	171,516	0	22,484	0
60.00 06000	LABORATORY	235,272	15,094	0	1,979	0
65.00 06500	RESPIRATORY THERAPY	179,462	2,688	0	352	0
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	591,321	0	0	0	0

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150166

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 3:13 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,202,857	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	169,139	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 URGENT CARE	136,826	80,916	0	10,607	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
114.00	11400 UTILIZATION REVIEW - SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,595,675	1,461,657	41,654	190,168	472,375	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,273,350	0	0	0	0	192.00
194.00	07950 INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,869,025	1,461,657	41,654	190,168	472,375	202.00
Cost Center Description		CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	0					11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	638,702				14.00
15.00	01500 PHARMACY	0	0	436,283			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	362,762		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	0	0	21,196	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	138,768	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	621	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	36,140	0	54.00
60.00	06000 LABORATORY	0	0	0	5,575	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	1,624	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	638,702	0	41,097	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	109,069	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	436,283	6,624	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 URGENT CARE	0	0	0	2,048	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
114.00	11400 UTILIZATION REVIEW - SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	638,702	436,283	362,762	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	638,702	436,283	362,762	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150166

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

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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
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,166,193	0	4,166,193	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	4,919,857	0	4,919,857	50.00
53.00	05300	2,304	0	2,304	53.00
54.00	05400	1,561,328	0	1,561,328	54.00
60.00	06000	714,624	0	714,624	60.00
65.00	06500	532,493	0	532,493	65.00
66.00	06600	0	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
71.00	07100	2,418,978	0	2,418,978	71.00
72.00	07200	6,588,065	0	6,588,065	72.00
73.00	07300	940,374	0	940,374	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	496,000	0	496,000	90.01
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
114.00	11400				114.00
118.00		22,340,216	0	22,340,216	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	3,745,144	0	3,745,144	192.00
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		26,085,360	0	26,085,360	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150166

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
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	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	402,917	286,236	689,153	5.00
7.00 00700	OPERATION OF PLANT	0	241,624	171,652	413,276	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,831	8,405	20,236	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	29,225	20,762	49,987	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	14,872	10,565	25,437	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	457,436	324,966	782,402	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	768,859	546,204	1,315,063	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	184,584	131,130	315,714	54.00
60.00 06000	LABORATORY	0	16,244	11,540	27,784	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,893	2,055	4,948	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	URGENT CARE	0	87,081	61,863	148,944	90.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,217,566	1,575,378	3,792,944	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	INDIANA BREAST CENTER	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,217,566	1,575,378	3,792,944	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150166

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

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	689,153					5.00
7.00	00700	38,616	451,892				7.00
8.00	00800	810	3,399	24,445			8.00
9.00	00900	5,024	0	0	5,024		9.00
10.00	01000	11,668	8,396	0	94	70,145	10.00
11.00	01100	0	0	0	0	0	11.00
14.00	01400	16,874	0	0	0	0	14.00
15.00	01500	11,113	4,272	0	48	0	15.00
16.00	01600	9,584	0	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	83,225	131,410	24,445	1,472	70,145	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	104,963	220,874	0	2,475	0	50.00
53.00	05300	44	0	0	0	0	53.00
54.00	05400	35,169	53,027	0	594	0	54.00
60.00	06000	18,281	4,667	0	52	0	60.00
65.00	06500	13,945	831	0	9	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	45,948	0	0	0	0	71.00
72.00	07200	171,171	0	0	0	0	72.00
73.00	07300	13,143	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	10,632	25,016	0	280	0	90.01
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
114.00	11400						114.00
118.00		590,210	451,892	24,445	5,024	70,145	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	98,943	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		689,153	451,892	24,445	5,024	70,145	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150166

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

Worksheet B
Part II
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Cost Center Description		CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
14.00	01400	0	16,874				14.00
15.00	01500	0	0	40,870			15.00
16.00	01600	0	0	0	9,584		16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	560		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	3,666		50.00
53.00	05300	0	0	0	16		53.00
54.00	05400	0	0	0	955		54.00
60.00	06000	0	0	0	147		60.00
65.00	06500	0	0	0	43		65.00
66.00	06600	0	0	0	0		66.00
67.00	06700	0	0	0	0		67.00
68.00	06800	0	0	0	0		68.00
71.00	07100	0	16,874	0	1,086		71.00
72.00	07200	0	0	0	2,882		72.00
73.00	07300	0	0	40,870	175		73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	54		90.01
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
114.00	11400						114.00
118.00		0	16,874	40,870	9,584	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0		192.00
194.00	07950	0	0	0	0		194.00
200.00							200.00
201.00		0	0	0	0		201.00
202.00		0	16,874	40,870	9,584		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150166

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

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Part II
Date/Time Prepared:
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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
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	1,093,659	0	1,093,659	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,647,041	0	1,647,041	50.00
53.00	05300	60	0	60	53.00
54.00	05400	405,459	0	405,459	54.00
60.00	06000	50,931	0	50,931	60.00
65.00	06500	19,776	0	19,776	65.00
66.00	06600	0	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
71.00	07100	63,908	0	63,908	71.00
72.00	07200	174,053	0	174,053	72.00
73.00	07300	54,188	0	54,188	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	184,926	0	184,926	90.01
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
114.00	11400				114.00
118.00		3,694,001	0	3,694,001	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	98,943	0	98,943	192.00
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		3,792,944	0	3,792,944	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150166

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	59,793				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		59,793			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	5,975,119		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,864	10,864	1,689,502	-8,869,025	5.00
7.00 00700	OPERATION OF PLANT	6,515	6,515	31,692	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	319	319	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	70,520	0	9.00
10.00 01000	DIETARY	788	788	98,838	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	164,205	0	14.00
15.00 01500	PHARMACY	401	401	212,832	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	109,428	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,334	12,334	961,727	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	20,731	20,731	1,122,323	0	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,977	4,977	482,672	0	54.00
60.00 06000	LABORATORY	438	438	83,571	0	60.00
65.00 06500	RESPIRATORY THERAPY	78	78	303,939	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	URGENT CARE	2,348	2,348	58,763	0	90.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	59,793	59,793	5,390,012	-8,869,025	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	585,107	0	192.00
194.00 07950	INDIANA BREAST CENTER	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,217,566	1,575,378	750,731		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	37.087385	26.347198	0.125643		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150166

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	42,414				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	319	97,774			8.00
9.00	00900	HOUSEKEEPING	0	0	42,095		9.00
10.00	01000	DIETARY	788	0	788	100	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	401	0	401	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,334	97,774	12,334	100	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,731	0	20,731	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,977	0	4,977	0	0 54.00
60.00	06000	LABORATORY	438	0	438	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	78	0	78	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	URGENT CARE	2,348	0	2,348	0	0 90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS							
114.00	11400	UTILIZATION REVIEW - SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,414	97,774	42,095	100	0 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,461,657	41,654	190,168	472,375	0 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.461664	0.426023	4.517591	4,723.750000	0.000000 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	451,892	24,445	5,024	70,145	0 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.654312	0.250015	0.119349	701.450000	0.000000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150166

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
14.00	01400	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	71,008,948		16.00
19.00	01900	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	0	4,148,785		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	0	27,165,652	0	50.00
53.00	05300	0	0	121,625	0	53.00
54.00	05400	0	0	7,073,825	0	54.00
60.00	06000	0	0	1,091,154	0	60.00
65.00	06500	0	0	317,886	0	65.00
66.00	06600	0	0	0	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
71.00	07100	100	0	8,044,101	0	71.00
72.00	07200	0	0	21,348,438	0	72.00
73.00	07300	0	100	1,296,552	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	0	0	400,930	0	90.01
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
114.00	11400					114.00
118.00		100	100	71,008,948	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00		638,702	436,283	362,762	0	202.00
203.00		6,387.020000	4,362.830000	0.005109	0.000000	203.00
204.00		16,874	40,870	9,584	0	204.00
205.00		168.740000	408.700000	0.000135	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150166

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 3:13 pm

		Title XVII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Disallowance	Total Costs	Inpatient		
			1.00	2.00	3.00	4.00	5.00	6.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	4,166,193		4,166,193	0	4,166,193	3,718,321	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	4,919,857		4,919,857	0	4,919,857	17,015,891	50.00
53.00	05300 ANESTHESIOLOGY	2,304		2,304	0	2,304	13,825	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,561,328		1,561,328	0	1,561,328	1,119,833	54.00
60.00	06000 LABORATORY	714,624		714,624	0	714,624	475,415	60.00
65.00	06500 RESPIRATORY THERAPY	532,493	0	532,493	0	532,493	259,434	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,418,978		2,418,978	0	2,418,978	3,677,467	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,588,065		6,588,065	0	6,588,065	11,544,216	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	940,374		940,374	0	940,374	917,388	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 URGENT CARE	496,000		496,000	0	496,000	10,337	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	441,108		441,108		441,108	68,968	92.00
SPECIAL PURPOSE COST CENTERS								
114.00	11400 UTILIZATION REVIEW - SNF		0		0			114.00
200.00	Subtotal (see instructions)	22,781,324		22,781,324	0	22,781,324	38,821,095	200.00
201.00	Less Observation Beds	441,108		441,108		441,108		201.00
202.00	Total (see instructions)	22,340,216	0	22,340,216	0	22,340,216	38,821,095	202.00
Charges								
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
	7.00	8.00						9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS		3,718,321					30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	10,149,761	27,165,652	0.181106	0.000000	0.181106		50.00
53.00	05300 ANESTHESIOLOGY	107,800	121,625	0.018943	0.000000	0.018943		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,953,992	7,073,825	0.220719	0.000000	0.220719		54.00
60.00	06000 LABORATORY	615,739	1,091,154	0.654925	0.000000	0.654925		60.00
65.00	06500 RESPIRATORY THERAPY	58,452	317,886	1.675107	0.000000	1.675107		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0.000000	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,366,634	8,044,101	0.300715	0.000000	0.300715		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,804,222	21,348,438	0.308597	0.000000	0.308597		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	379,164	1,296,552	0.725288	0.000000	0.725288		73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 URGENT CARE	390,593	400,930	1.237124	0.000000	1.237124		90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	361,496	430,464	1.024727	0.000000	1.024727		92.00
SPECIAL PURPOSE COST CENTERS								
114.00	11400 UTILIZATION REVIEW - SNF							114.00
200.00	Subtotal (see instructions)	32,187,853	71,008,948					200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	32,187,853	71,008,948					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150166

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

Worksheet C Part I Date/Time Prepared: 5/30/2013 3:13 pm

		Title XIX			Hospital			
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Disallowance	Total Costs	Inpatient		
			1.00	2.00	3.00	4.00	5.00	6.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	4,166,193		4,166,193	0	0	3,718,321	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	4,919,857		4,919,857	0	0	17,015,891	50.00
53.00	05300 ANESTHESIOLOGY	2,304		2,304	0	0	13,825	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,561,328		1,561,328	0	0	1,119,833	54.00
60.00	06000 LABORATORY	714,624		714,624	0	0	475,415	60.00
65.00	06500 RESPIRATORY THERAPY	532,493	0	532,493	0	0	259,434	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,418,978		2,418,978	0	0	3,677,467	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,588,065		6,588,065	0	0	11,544,216	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	940,374		940,374	0	0	917,388	73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 URGENT CARE	496,000		496,000	0	0	10,337	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	441,108		441,108		0	68,968	92.00
SPECIAL PURPOSE COST CENTERS								
114.00	11400 UTILIZATION REVIEW - SNF							114.00
200.00	Subtotal (see instructions)	22,781,324	0	22,781,324	0	0	38,821,095	200.00
201.00	Less Observation Beds	441,108		441,108		0		201.00
202.00	Total (see instructions)	22,340,216	0	22,340,216	0	0	38,821,095	202.00
Charges								
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
	7.00	8.00					9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS		3,718,321					30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	10,149,761	27,165,652	0.181106	0.000000	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	107,800	121,625	0.018943	0.000000	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,953,992	7,073,825	0.220719	0.000000	0.000000		54.00
60.00	06000 LABORATORY	615,739	1,091,154	0.654925	0.000000	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	58,452	317,886	1.675107	0.000000	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0.000000	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,366,634	8,044,101	0.300715	0.000000	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,804,222	21,348,438	0.308597	0.000000	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	379,164	1,296,552	0.725288	0.000000	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 URGENT CARE	390,593	400,930	1.237124	0.000000	0.000000		90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	361,496	430,464	1.024727	0.000000	0.000000		92.00
SPECIAL PURPOSE COST CENTERS								
114.00	11400 UTILIZATION REVIEW - SNF							114.00
200.00	Subtotal (see instructions)	32,187,853	71,008,948					200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	32,187,853	71,008,948					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150166		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/30/2013 3:13 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,093,659	0	1,093,659	2,909	375.96	30.00
200.00	Total (Lines 30-199)	1,093,659		1,093,659	2,909		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,244	467,694				
200.00	Total (Lines 30-199)	1,244	467,694				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/30/2013 3:13 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. C, 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	1,647,041	27,165,652	0.060630	2,502,332	151,716	50.00
53.00	05300 ANESTHESIOLOGY	60	121,625	0.000493	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	405,459	7,073,825	0.057318	570,507	32,700	54.00
60.00	06000 LABORATORY	50,931	1,091,154	0.046676	344,818	16,095	60.00
65.00	06500 RESPIRATORY THERAPY	19,776	317,886	0.062211	161,352	10,038	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63,908	8,044,101	0.007945	1,489,416	11,833	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	174,053	21,348,438	0.008153	7,364,885	60,046	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54,188	1,296,552	0.041794	465,000	19,434	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 URGENT CARE	184,926	400,930	0.461243	5,546	2,558	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	115,794	430,464	0.268998	44,320	11,922	92.00
200.00	Total (lines 50-199)	2,716,136	67,290,627		12,948,176	316,342	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150166		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/30/2013 3:13 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,909	0.00	1,244	0	30.00	
200.00		Total (lines 30-199)	2,909		1,244	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 3:13 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
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
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	URGENT CARE	0	0	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 3:13 pm
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Cost Center Description	Title XVIII			Hospital		PPS	
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,165,652	0.000000	0.000000	2,502,332	50.00
53.00	05300 ANESTHESIOLOGY	0	121,625	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,073,825	0.000000	0.000000	570,507	54.00
60.00	06000 LABORATORY	0	1,091,154	0.000000	0.000000	344,818	60.00
65.00	06500 RESPIRATORY THERAPY	0	317,886	0.000000	0.000000	161,352	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,044,101	0.000000	0.000000	1,489,416	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	21,348,438	0.000000	0.000000	7,364,885	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,296,552	0.000000	0.000000	465,000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 URGENT CARE	0	400,930	0.000000	0.000000	5,546	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	430,464	0.000000	0.000000	44,320	92.00
200.00	Total (lines 50-199)	0	67,290,627			12,948,176	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 3:13 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	3,639,520	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,665,222	0	54.00
60.00	06000 LABORATORY	0	57,760	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	16,925	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	816,522	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,474,824	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	102,899	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 URGENT CARE	0	38,439	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	100,385	0	92.00
200.00	Total (lines 50-199)	0	7,912,496	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 3:13 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.181106	3,639,520	0	0	659,139	50.00
53.00 05300 ANESTHESIOLOGY	0.018943	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.220719	1,665,222	0	92	367,546	54.00
60.00 06000 LABORATORY	0.654925	57,760	0	0	37,828	60.00
65.00 06500 RESPIRATORY THERAPY	1.675107	16,925	0	0	28,351	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300715	816,522	0	0	245,540	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.308597	1,474,824	0	0	455,126	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.725288	102,899	0	195	74,631	73.00
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 URGENT CARE	1.237124	38,439	0	0	47,554	90.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.024727	100,385	0	0	102,867	92.00
200.00 Subtotal (see instructions)		7,912,496	0	287	2,018,582	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		7,912,496	0	287	2,018,582	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 3:13 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
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	20	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
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	141	73.00
OUTPATIENT SERVICE COST CENTERS				
90.01	09001 URGENT CARE	0	0	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	161	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	161	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2013 3:13 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,909	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,909	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)		2,601	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,244	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,166,193	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,166,193	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,201,566	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,201,566	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.991581	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)		1,615.37	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,166,193	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)		1,432.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,781,619	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)		1,781,619	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/30/2013 3:13 pm
Title XVIII			Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,185,428 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,967,047 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)					467,694 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					316,342 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					784,036 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,183,011 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					308 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,432.17 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					441,108 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150166		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 3:13 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,093,659	4,166,193	0.262508	441,108	115,794	90.00
91.00	Nursing School cost	0	4,166,193	0.000000	441,108	0	91.00
92.00	Allied health cost	0	4,166,193	0.000000	441,108	0	92.00
93.00	All other Medical Education	0	4,166,193	0.000000	441,108	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 3:13 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		1,819,270		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.181106	2,502,332	453,187	50.00
53.00	05300 ANESTHESIOLOGY	0.018943	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220719	570,507	125,922	54.00
60.00	06000 LABORATORY	0.654925	344,818	225,830	60.00
65.00	06500 RESPIRATORY THERAPY	1.675107	161,352	270,282	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300715	1,489,416	447,890	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.308597	7,364,885	2,272,781	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.725288	465,000	337,259	73.00
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 URGENT CARE	1.237124	5,546	6,861	90.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.024727	44,320	45,416	92.00
200.00	Total (sum of lines 50-94 and 96-98)		12,948,176	4,185,428	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		12,948,176		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/30/2013 3:13 pm
		Title XVII I	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		2,432,038	1.00
2.00	Outlier payments for discharges. (see instructions)		1,639,267	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		17.16	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		4,071,305	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		4,071,305	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		832,332	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/30/2013 3:13 pm
		Title XVII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			4,903,637 59.00
60.00	Primary payer payments			37,738 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			4,865,899 61.00
62.00	Deductibles billed to program beneficiaries			269,300 62.00
63.00	Coinurance billed to program beneficiaries			6,069 63.00
64.00	Allowable bad debts (see instructions)			0 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,590,530 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			-994 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-1,671 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			4,587,865 71.00
72.00	Interim payments			4,587,865 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			0 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			0 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/30/2013 3:13 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		161	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		2,018,582	2.00
3.00	PPS payments		1,471,344	3.00
4.00	Outlier payment (see instructions)		62,759	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)		161	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		287	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)		287	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)		287	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		126	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)		161	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)		1,534,103	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		331,710	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,202,554	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,202,554	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,202,554	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		1,202,554	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)		1,202,554	40.00
41.00	Interim payments		1,202,416	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)		138	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150166

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2013 3:13 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,587,865		1,202,416	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,587,865		1,202,416	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		138	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,587,865		1,202,554	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 150166

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

Worksheet G

Date/Time Prepared:
5/30/2013 3:13 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	4,002,127	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	4,253,213	0	0	0	4.00
5.00	Other receivable	26,074	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	626,079	0	0	0	7.00
8.00	Prepaid expenses	335,287	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)	9,242,780	0	0	0	11.00
FIXED ASSETS						
12.00	Land	25,000	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	211,203	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	13,396,783	0	0	0	23.00
24.00	Accumulated depreciation	-10,594,553	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)	3,038,433	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	415,135	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	415,135	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,696,348	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,104,972	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,818,510	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,491,334	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	88,576	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,503,392	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	7,808,930	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,808,930	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,312,322	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-4,615,974	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-4,615,974	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,696,348	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150166

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

Worksheet G-1

Date/Time Prepared:
5/30/2013 3:13 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		-3,928,278		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-687,690				2.00
3.00	Total (sum of line 1 and line 2)		-4,615,968		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)		-4,615,968		0		11.00
12.00	ROUNDING	6		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)		6		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,615,974		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	ROUNDING		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: 150166

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2013 3:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,201,566		4,201,566	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,201,566		4,201,566	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,201,566		4,201,566	17.00
18.00	Ancillary services	35,002,401	31,321,097	66,323,498	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	URGENT CARE	10,337	394,174	404,511	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	2,073,683	2,073,683	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	39,214,304	33,788,954	73,003,258	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,789,754		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,789,754		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150166

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

Worksheet G-3

Date/Time Prepared:
5/30/2013 3:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	73,003,258	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,041,109	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,962,149	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,789,754	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-827,605	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,463	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	16,446	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	-2,238	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	90,654	24.00
24.01	FACILITY FEES	27,590	24.01
25.00	Total other income (sum of lines 6-24)	139,915	25.00
26.00	Total (line 5 plus line 25)	-687,690	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)	-687,690	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150166	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/30/2013 3:13 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		196,035	1.00
2.00	Capital DRG outlier payments		636,297	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		7.11	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		832,332	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

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