

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: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/23/2013 2:39 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/23/2013	Time: 2:39 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (151304) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII		HIT	Title XIX		
	Title V	Part A				Part B
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-76,710	272,605	-3,958	-116,242	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-55,260	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-131,970	272,605	-3,958	-116,242	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: 151304			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/23/2013 2:38 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1300 NORTH MAIN STREET			PO Box:						1.00	
2.00	City: RUSHVILLE			State: IN		Zip Code: 46173-		County: RUSH		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	0	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		RUSH SWING BEDS	152304	99915		08/01/2000	N	0	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		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		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	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	0	0	25.00	
							Urban/Rural	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/23/2013 2:38 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
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.					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151304

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

Worksheet S-2
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	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		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical		Occupational		
		1.00		2.00		
		Speech		Respiratory		
		3.00		4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y		Y		109.00
				N		
		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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	176,341	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)		N		
		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	
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

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								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							141,352	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: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/23/2013 2:38 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/01/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/23/2013 2:38 pm
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	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		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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-633-4705		MALESSANDRI NI@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	05/01/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
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.	CONSULTANT	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: 151304

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps		
					Title V		
	1.00	2.00	3.00	4.00	5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	39,336.00	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)		25	9,150	39,336.00	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)		25	9,150	39,336.00	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 HOSPI CE						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)		25				27.00	
28.00 Observation Bed Days					0	28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
33.00 LTCH non-covered days						33.00	
				I/P Days / O/P Visi ts / Tri ps		Full Time Equivalents	
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,135	105	1,656			1.00	
2.00 HMO	74	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	554	0	579			5.00	
6.00 Hospital Adults & Peds. Swing Bed NF		0	59			6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,689	105	2,294			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)	1,689	105	2,294	0.00	231.10	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 HOSPI CE						24.00	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151304

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
27.00	Total (sum of lines 14-26)						27.00
28.00				0.00	231.10	28.00	
29.00	Observation Bed Days		58			29.00	
30.00	Ambulance Trips	690				30.00	
31.00	Employee discount days (see instruction)			0		31.00	
32.00	Employee discount days - IRF			0		32.00	
33.00	Labor & delivery days (see instructions)		0	0		33.00	
33.00	LTCH non-covered days	0				33.00	
Component	Full Time Equivalents	Discharges			Total All Patients		
	Nonpaid Workers	Title V	Title XVIII	Title XIX			
	11.00	12.00	13.00	14.00			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	365	33	544	1.00
2.00	HMO			17			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	365	33	544	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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/23/2013 2:38 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)		0.381375	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,469,272	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		7,321,763	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,792,337	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,323,065	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		423,153	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,323,065	19.00	
			1.00		
			Insured patients		
			2.00		
			Total (col. 1 + col. 2)		
			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	584,942	0	584,942	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	223,082	0	223,082	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)	223,082	0	223,082	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,739,346	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		288,949	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		4,450,397	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,697,270	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,920,352	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,243,417	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151304

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

Worksheet A
Date/Time Prepared:
5/23/2013 2:38 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		1,630,197	1,630,197	0	1,630,197	1.00
4.00	00400	EMPLOYEE BENEFITS	259,340	2,117,478	2,376,818	0	2,376,818	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,905,855	1,978,573	3,884,428	0	3,884,428	5.00
7.00	00700	OPERATION OF PLANT	189,161	464,956	654,117	1,141	655,258	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	58,649	58,649	8.00
9.00	00900	HOUSEKEEPING	262,281	128,905	391,186	-58,649	332,537	9.00
10.00	01000	DIETARY	329,211	266,867	596,078	-413,114	182,964	10.00
11.00	01100	CAFETERIA	0	0	0	413,114	413,114	11.00
13.00	01300	NURSING ADMINISTRATION	21,835	142	21,977	0	21,977	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,365	138,939	193,304	-107,494	85,810	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	242,740	96,603	339,343	0	339,343	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	844,597	72,765	917,362	913	918,275	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	296,919	376,704	673,623	-32,728	640,895	50.00
51.00	05100	RECOVERY ROOM	0	1,684	1,684	32,728	34,412	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	764,432	989,686	1,754,118	0	1,754,118	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	547,786	720,485	1,268,271	0	1,268,271	60.00
65.00	06500	RESPIRATORY THERAPY	88,250	5,997	94,247	0	94,247	65.00
66.00	06600	PHYSICAL THERAPY	235,337	155,211	390,548	0	390,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,272	1,428	221,700	0	221,700	67.00
68.00	06800	SPEECH PATHOLOGY	12,978	1,672	14,650	0	14,650	68.00
69.00	06900	ELECTROCARDIOLOGY	167,884	3,750	171,634	0	171,634	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,463	14,463	107,494	121,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	50,268	50,268	0	50,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321,208	1,709,936	2,031,144	0	2,031,144	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,524,184	447,201	2,971,385	0	2,971,385	90.00
91.00	09100	EMERGENCY	735,872	832,506	1,568,378	3,651	1,572,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	589,545	90,294	679,839	-5,705	674,134	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,614,052	12,296,710	22,910,762	0	22,910,762	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100	1,790	1,890	0	1,890	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	35,379	-182	35,197	0	35,197	193.01
193.02	19302	OCCUPATIONAL MEDICINE	35,907	4,235	40,142	0	40,142	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	10,685,438	12,302,553	22,987,991	0	22,987,991	200.00
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	-145,925	1,484,272				1.00
4.00	00400	EMPLOYEE BENEFITS	-347	2,376,471				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,306,213	2,578,215				5.00
7.00	00700	OPERATION OF PLANT	-98	655,160				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,649				8.00
9.00	00900	HOUSEKEEPING	-289	332,248				9.00
10.00	01000	DIETARY	-2,439	180,525				10.00
11.00	01100	CAFETERIA	-186,200	226,914				11.00
13.00	01300	NURSING ADMINISTRATION	-759	21,218				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,686	83,124				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,827	329,516				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	-53	918,222				30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	-285,282	355,613				50.00
51.00	05100	RECOVERY ROOM	0	34,412				51.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-570,027	1,184,091				54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				55.00
60.00	06000	LABORATORY	-871	1,267,400				60.00
65.00	06500	RESPIRATORY THERAPY	0	94,247				65.00
66.00	06600	PHYSICAL THERAPY	-30,066	360,482				66.00
67.00	06700	OCCUPATIONAL THERAPY	0	221,700				67.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151304

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

Worksheet A
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
68.00	06800	SPEECH PATHOLOGY	0	14,650	68.00
69.00	06900	ELECTROCARDIOLOGY	-33	171,601	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-887	121,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	50,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-17,379	2,013,765	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,927,367	1,044,018	90.00
91.00	09100	EMERGENCY	-1,177	1,570,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	674,134	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,487,925	18,422,837	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,890	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	35,197	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	40,142	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,487,925	18,500,066	200.00

RECLASSIFICATIONS

Provider CCN: 151304

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

Worksheet A-6

Date/Time Prepared:
5/23/2013 2:38 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - SALARY RECLASS					
1.00	RECOVERY ROOM	51.00	32,728	0	1.00
	TOTALS		32,728	0	
B - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	58,649	1.00
	TOTALS		0	58,649	
C - DIETARY/CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	228,161	184,953	1.00
	TOTALS		228,161	184,953	
D - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	107,494	1.00
	TOTALS		0	107,494	
E - AMBULANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	1,141	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	913	0	2.00
3.00	EMERGENCY	91.00	3,651	0	3.00
	TOTALS		5,705	0	
500.00	Grand Total: Increases		266,594	351,096	500.00

RECLASSIFICATIONS

Provider CCN: 151304

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

Worksheet A-6

Date/Time Prepared:
5/23/2013 2:38 pm

		Decreases						
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.			
6.00		7.00	8.00	9.00	10.00			
A - SALARY RECLASS								
1.00	OPERATING ROOM	50.00	32,728	0	0	0		1.00
	TOTALS		32,728	0				
B - LAUNDRY RECLASS								
1.00	HOUSEKEEPING	9.00	0	58,649	0	0		1.00
	TOTALS		0	58,649				
C - DIETARY/CAFETERIA RECLASS								
1.00	DIETARY	10.00	228,161	184,953	0	0		1.00
	TOTALS		228,161	184,953				
D - MEDICAL SUPPLY RECLASS								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	107,494	0	0		1.00
	TOTALS		0	107,494				
E - AMBULANCE RECLASS								
1.00	AMBULANCE SERVICES	95.00	5,705	0	0	0		1.00
2.00		0.00	0	0	0	0		2.00
3.00		0.00	0	0	0	0		3.00
	TOTALS		5,705	0				
500.00	Grand Total: Decreases		266,594	351,096				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	164,978	0	0	0	1.00
2.00	Land Improvements	235,798	51,659	0	51,659	2.00
3.00	Buildings and Fixtures	12,046,900	429,617	0	429,617	3.00
4.00	Building Improvements	618,150	0	0	0	4.00
5.00	Fixed Equipment	745,933	62,269	0	62,269	5.00
6.00	Movable Equipment	10,671,193	821,281	0	821,281	6.00
7.00	HIT designated Assets	141,352	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,624,304	1,364,826	0	1,364,826	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,624,304	1,364,826	0	1,364,826	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	164,978	0			1.00
2.00	Land Improvements	287,457	0			2.00
3.00	Buildings and Fixtures	12,476,517	0			3.00
4.00	Building Improvements	401,276	0			4.00
5.00	Fixed Equipment	808,202	0			5.00
6.00	Movable Equipment	10,241,928	0			6.00
7.00	HIT designated Assets	141,352	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,521,710	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	24,521,710	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Part II
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,205,291	0	188,068	236,838	0	1.00
3.00	Total (sum of lines 1-2)	1,205,291	0	188,068	236,838	0	3.00

Cost Center Description		SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,630,197	1.00
3.00	Total (sum of lines 1-2)	0	1,630,197	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Part III
Date/Time Prepared:
5/23/2013 2:38 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	24,521,710	0	24,521,710	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	24,521,710	0	24,521,710	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	1,099,237	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,099,237	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	148,197	236,838	0	0	1,484,272	1.00
3.00	Total (sum of lines 1-2)	148,197	236,838	0	0	1,484,272	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151304

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

Worksheet A-8

Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,781,037	0			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		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			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		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-105,385		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00 CAFETERIA	B	-85,905		CAFETERIA	11.00	0	33.00
34.00 JAIL MEALS	B	-100,295		CAFETERIA	11.00	0	34.00
35.00 VENDING MACHINES	B	-3		ADMINISTRATIVE & GENERAL	5.00	0	35.00

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	
36.00 SALE OF DRUGS	B	-11,594	DRUGS CHARGED TO PATIENTS	73.00	0 36.00
37.00 SALE OF SUPPLIES	B	-643	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 37.00
38.00 PHYSICIAN APPLICATION FEES	B	-3,250	ADMINISTRATIVE & GENERAL	5.00	0 38.00
39.00 NSF FEES	B	-250	EMPLOYEE BENEFITS	4.00	0 39.00
40.00 MEDICAL RECORDS TRANSCRIPTION FEES	B	-9,827	MEDICAL RECORDS & LIBRARY	16.00	0 40.00
41.00 COPIER FEES	B	-19,752	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 ATHLETIC TRAINER - SCHOOL REV	B	-16,000	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00 INTEREST FUNDED DEPRECIATION	B	-1,309	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 43.00
44.00 WELLNESS PROGRAM	B	-81	EMPLOYEE BENEFITS	4.00	0 44.00
45.00 SALE OF SCRAP	B	-2,686	CENTRAL SERVICES & SUPPLY	14.00	0 45.00
45.01 MISC. INCOME	B	-16	EMPLOYEE BENEFITS	4.00	0 45.01
45.02 MISC. INCOME	B	-1,973	ADMINISTRATIVE & GENERAL	5.00	0 45.02
45.03 MISC. INCOME	B	-145	DIETARY	10.00	0 45.03
45.04 MISC. INCOME	B	-350	EMERGENCY	91.00	0 45.04
45.05 INTEREST INCOME	B	-38,562	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 45.05
45.06 TELEPHONE SALARY	A	-3,795	ADMINISTRATIVE & GENERAL	5.00	0 45.06
45.07 TELEPHONE OTHER	A	-857	ADMINISTRATIVE & GENERAL	5.00	0 45.07
45.08 TELEPHONE BENEFITS	A	-602	ADMINISTRATIVE & GENERAL	5.00	0 45.08
45.09 ADVERTISING	A	-131,062	ADMINISTRATIVE & GENERAL	5.00	0 45.09
45.10 IHA & AHA LOBBYING	A	-3,199	ADMINISTRATIVE & GENERAL	5.00	0 45.10
45.11 REBATES	B	-669	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 45.11
45.12 REBATES	B	-4,607	ADMINISTRATIVE & GENERAL	5.00	0 45.12
45.13 REBATES	B	-98	OPERATION OF PLANT	7.00	0 45.13
45.14 REBATES	B	-289	HOUSEKEEPING	9.00	0 45.14
45.15 REBATES	B	-2,294	DIETARY	10.00	0 45.15
45.16 REBATES	B	-759	NURSING ADMINISTRATIVE	13.00	0 45.16
45.17 REBATES	B	-53	ADULTS & PEDIATRICS	30.00	0 45.17
45.18 REBATES	B	-962	OPERATING ROOM	50.00	0 45.18
45.19 REBATES	B	-551	RADIOLOGY-DIAGNOSTIC	54.00	0 45.19
45.20 REBATES	B	-871	LABORATORY	60.00	0 45.20
45.21 REBATES	B	-33	ELECTROCARDIOLOGY	69.00	0 45.21
45.22 REBATES	B	-244	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 45.22
45.23 REBATES	B	-5,785	DRUGS CHARGED TO PATIENTS	73.00	0 45.23
45.24 REBATES	B	-126	CLINIC	90.00	0 45.24
45.25 REBATES	B	-827	EMERGENCY	91.00	0 45.25
45.26 HAF EXPENSE	A	-1,035,411	ADMINISTRATIVE & GENERAL	5.00	0 45.26
45.27 SPONSORSHIPS	A	-1,648	ADMINISTRATIVE & GENERAL	5.00	0 45.27
45.28 PHYSICIAN RECRUITMENTS	A	-84,054	ADMINISTRATIVE & GENERAL	5.00	0 45.28
45.29 MESSAGE REVENUE	B	-30,066	PHYSICAL THERAPY	66.00	0 45.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,487,925			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151304

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2013 2:38 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	50.00	OPERATING ROOM	291,163	284,320	6,842	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	594,476	569,476	25,000	0	0	2.00
3.00	60.00	LABORATORY	36,000	0	36,000	0	0	3.00
4.00	90.00	CLINIC	2,072,223	1,927,241	144,982	0	0	4.00
5.00	91.00	EMERGENCY	771,449	0	771,449	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			3,765,311	2,781,037	984,273			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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	50.00	OPERATING ROOM	0	0	0	284,320		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	569,476		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	90.00	CLINIC	0	0	0	1,927,241		4.00
5.00	91.00	EMERGENCY	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	2,781,037		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/23/2013 2:38 pm	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					32	1.00
2.00	Line 1 multiplied by 15 hours per week					480	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					108	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	636.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.69	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.85	36.85	0.00			11.00
12.00	Number of travel hours (provider site)	0	53	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	6,343	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					46,867	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					46,867	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					46,867	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					46,867	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					3,980	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,980	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,980	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					3,906	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					3,906	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,980	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/23/2013 2:38 pm	
						Physical Therapy		Cost	
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		0.00	49.00
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.69	0.00	0.00	0.00	0.00		0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		0	56.00
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							46,867	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							3,980	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							50,847	63.00
64.00	Total cost of outside supplier services (from your records)							42,522	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							3,980	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							3,980	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							3,906	101.01
101.02	Line 34 = sum of lines 27 and 31							3,906	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							3,906	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							3,906	102.02

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				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					17	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	78.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.85	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.93	34.93	0.00			11.00
12.00	Number of travel hours (provider site)	0	13	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	1,250	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					5,448	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					5,448	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					5,448	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.85	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					8,382	22.00
23.00	Total salary equivalency (see instructions)					8,382	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					594	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					594	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					594	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					908	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					908	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					594	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

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				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.85	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					8,382	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					594	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					8,976	63.00
64.00	Total cost of outside supplier services (from your records)					5,942	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					594	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					594	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					908	101.01
101.02	Line 34 = sum of lines 27 and 31					908	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					908	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					908	102.02

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		Speech Pathology		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					12	1.00
2.00	Line 1 multiplied by 15 hours per week					180	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					19	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	48.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.57	33.57	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	1,219	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					3,240	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					3,240	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					3,240	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.15	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					12,087	22.00
23.00	Total salary equivalency (see instructions)					12,087	23.00
Part III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					638	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					638	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					638	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					638	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151304				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/23/2013 2:38 pm	
		Speech Pathology				Cost			
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.14	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					12,087		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					638		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					12,725		63.00	
64.00	Total cost of outside supplier services (from your records)					3,992		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					638		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					638		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1,484,272	1,484,272					1.00
4.00 00400 EMPLOYEE BENEFITS	2,376,471	13,567		2,390,038			4.00
5.00 00500 ADMINISTRATIVE & GENERAL	2,578,215	278,578		436,891	3,293,684	3,293,684	5.00
7.00 00700 OPERATION OF PLANT	655,160	153,640		43,624	852,424	184,634	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	58,649	6,030		0	64,679	14,009	8.00
9.00 00900 HOUSEKEEPING	332,248	28,398		60,124	420,770	91,138	9.00
10.00 01000 DIETARY	180,525	56,693		23,164	260,382	56,398	10.00
11.00 01100 CAFETERIA	226,914	18,823		52,303	298,040	64,555	11.00
13.00 01300 NURSING ADMINISTRATION	21,218	12,528		5,005	38,751	8,393	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	83,124	40,274		12,462	135,860	29,427	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	329,516	29,090		55,645	414,251	89,726	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	918,222	126,343		193,821	1,238,386	268,233	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	355,613	110,575		60,562	526,750	114,094	50.00
51.00 05100 RECOVERY ROOM	34,412	12,793		7,502	54,707	11,849	51.00
53.00 05300 ANESTHESIOLOGY	0	0		0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,184,091	154,537		175,235	1,513,863	327,901	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		0	0	0	55.00
60.00 06000 LABORATORY	1,267,400	64,923		125,572	1,457,895	315,779	60.00
65.00 06500 RESPIRATORY THERAPY	94,247	2,669		20,230	117,146	25,374	65.00
66.00 06600 PHYSICAL THERAPY	360,482	69,405		53,948	483,835	104,798	66.00
67.00 06700 OCCUPATIONAL THERAPY	221,700	26,279		50,494	298,473	64,649	67.00
68.00 06800 SPEECH PATHOLOGY	14,650	1,711		2,975	19,336	4,188	68.00
69.00 06900 ELECTROCARDIOLOGY	171,601	8,189		38,485	218,275	47,278	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	121,070	0		0	121,070	26,224	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	50,268	0		0	50,268	10,888	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,013,765	7,252		73,632	2,094,649	453,697	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	1,044,018	132,393		578,638	1,755,049	380,142	90.00
91.00 09100 EMERGENCY	1,570,852	78,592		169,525	1,818,969	393,987	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	674,134	19,679		133,837	827,650	179,268	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,422,837	1,452,961	2,373,674	18,375,162	3,266,629	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1,890	23,040		23	24,953	5,405	192.00
193.00 19300 NONPAID WORKERS	0	0		0	0	0	193.00
193.01 19301 FOUNDATION	35,197	5,113		8,110	48,420	10,488	193.01
193.02 19302 OCCUPATIONAL MEDICINE	40,142	3,158		8,231	51,531	11,162	193.02
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	0	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers				0	0	201.00
202.00	TOTAL (sum lines 118-201)	18,500,066	1,484,272	2,390,038	18,500,066	3,293,684	202.00
Cost Center Description							
	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	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
4.00 00400 EMPLOYEE BENEFITS							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
7.00 00700 OPERATION OF PLANT	1,037,058						7.00
8.00 00800 LAUNDRY & LINEN SERVICE	6,022	84,710					8.00
9.00 00900 HOUSEKEEPING	28,358	5,946	546,212				9.00
10.00 01000 DIETARY	56,615	2,438	30,841	406,674			10.00
11.00 01100 CAFETERIA	18,797	0	10,240	0	391,632		11.00
13.00 01300 NURSING ADMINISTRATION	12,511	0	6,815	0	1,493		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	40,219	0	21,909	0	5,972		14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	29,050	0	15,825	0	17,666		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	126,169	55,234	68,731	406,674	50,260		30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	110,423	5,544	60,153	0	12,938		50.00
51.00 05100 RECOVERY ROOM	12,776	0	6,960	0	2,488		51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	154,324	3,582	84,068	0	38,815		54.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	64,834	0	35,318	0	34,087	60.00
65.00	06500	RESPIRATORY THERAPY	2,665	713	1,452	0	4,976	65.00
66.00	06600	PHYSICAL THERAPY	69,309	1,668	37,757	0	13,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,243	767	14,296	0	7,464	67.00
68.00	06800	SPEECH PATHOLOGY	1,709	33	931	0	249	68.00
69.00	06900	ELECTROCARDIOLOGY	8,178	0	4,455	0	6,967	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,242	0	3,945	0	12,441	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	132,211	0	72,022	0	9,455	90.00
91.00	09100	EMERGENCY	78,484	8,785	42,755	0	43,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	19,652	0	10,705	0	46,528	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,005,791	84,710	529,178	406,674	308,529	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,008	0	12,534	0	81,361	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	5,106	0	2,782	0	1,742	193.01
193.02	19302	OCCUPATIONAL MEDICINE	3,153	0	1,718	0	0	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	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)	1,037,058	84,710	546,212	406,674	391,632	202.00
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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						11.00
13.00	01300	NURSING ADMINISTRATION	67,963					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	233,387				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	595	567,113			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,449	15,040	243,666	2,501,842	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,578	20,341	53,587	911,408	0	50.00
51.00	05100	RECOVERY ROOM	1,406	492	0	90,678	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,198	64,882	2,200,633	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	92,123	0	2,000,036	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,962	1,437	1,202	157,927	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,127	0	714,179	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77	0	411,969	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	385	0	26,831	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	468	0	285,621	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,418	0	178,712	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	14,428	0	75,584	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,320	1,254	0	2,574,548	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	15,662	0	2,364,541	0	90.00
91.00	09100	EMERGENCY	25,248	15,097	203,776	2,630,146	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	7,607	0	1,091,410	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,963	232,749	567,113	18,216,065	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	451	0	147,712	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	16.00	24.00	25.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	68,538	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	187	0	67,751	0	193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,963	233,387	567,113	18,500,066	0	202.00
Cost Center Description			Total					
			26.00					
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
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						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,501,842					30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	911,408					50.00
51.00	05100	RECOVERY ROOM	90,678					51.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,200,633					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0					55.00
60.00	06000	LABORATORY	2,000,036					60.00
65.00	06500	RESPIRATORY THERAPY	157,927					65.00
66.00	06600	PHYSICAL THERAPY	714,179					66.00
67.00	06700	OCCUPATIONAL THERAPY	411,969					67.00
68.00	06800	SPEECH PATHOLOGY	26,831					68.00
69.00	06900	ELECTROCARDIOLOGY	285,621					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,712					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	75,584					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,574,548					73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,364,541					90.00
91.00	09100	EMERGENCY	2,630,146					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,091,410					95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,216,065					118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	147,712					192.00
193.00	19300	NONPAID WORKERS	0					193.00
193.01	19301	FOUNDATION	68,538					193.01
193.02	19302	OCCUPATIONAL MEDICINE	67,751					193.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0					194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0					201.00
202.00		TOTAL (sum lines 118-201)	18,500,066					202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS	0	13,567	13,567	13,567		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	278,578	278,578	2,480	281,058	5.00
7.00 00700	OPERATION OF PLANT	0	153,640	153,640	248	15,755	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,030	6,030	0	1,195	8.00
9.00 00900	HOUSEKEEPING	0	28,398	28,398	341	7,777	9.00
10.00 01000	DIETARY	0	56,693	56,693	131	4,813	10.00
11.00 01100	CAFETERIA	0	18,823	18,823	297	5,509	11.00
13.00 01300	NURSING ADMINISTRATION	0	12,528	12,528	28	716	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	40,274	40,274	71	2,511	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	29,090	29,090	316	7,657	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	126,343	126,343	1,100	22,889	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	110,575	110,575	344	9,736	50.00
51.00 05100	RECOVERY ROOM	0	12,793	12,793	43	1,011	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	154,537	154,537	995	27,981	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 06000	LABORATORY	0	64,923	64,923	713	26,946	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,669	2,669	115	2,165	65.00
66.00 06600	PHYSICAL THERAPY	0	69,405	69,405	306	8,943	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	26,279	26,279	287	5,517	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,711	1,711	17	357	68.00
69.00 06900	ELECTROCARDIOLOGY	0	8,189	8,189	218	4,034	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,238	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	929	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	7,252	7,252	418	38,715	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	132,393	132,393	3,284	32,439	90.00
91.00 09100	EMERGENCY	0	78,592	78,592	962	33,620	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	19,679	19,679	760	15,297	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,452,961	1,452,961	13,474	278,750	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	23,040	23,040	0	461	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	FOUNDATION	0	5,113	5,113	46	895	193.01
193.02 19302	OCCUPATIONAL MEDICINE	0	3,158	3,158	47	952	193.02
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,484,272	1,484,272	13,567	281,058	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		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
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	169,643				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	985	8,210			8.00
9.00	00900	HOUSEKEEPING	4,639	576	41,731		9.00
10.00	01000	DIETARY	9,261	236	2,356	73,490	10.00
11.00	01100	CAFETERIA	3,075	0	782	0	28,486
13.00	01300	NURSING ADMINISTRATION	2,047	0	521	0	109
14.00	01400	CENTRAL SERVICES & SUPPLY	6,579	0	1,674	0	434
16.00	01600	MEDICAL RECORDS & LIBRARY	4,752	0	1,209	0	1,285
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,639	5,355	5,251	73,490	3,656
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,063	537	4,596	0	941
51.00	05100	RECOVERY ROOM	2,090	0	532	0	181
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,241	347	6,423	0	2,823
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
60.00	06000	LABORATORY	10,606	0	2,698	0	2,479
65.00	06500	RESPIRATORY THERAPY	436	69	111	0	362
66.00	06600	PHYSICAL THERAPY	11,338	162	2,885	0	995
67.00	06700	OCCUPATIONAL THERAPY	4,293	74	1,092	0	543
68.00	06800	SPEECH PATHOLOGY	280	3	71	0	18
69.00	06900	ELECTROCARDIOLOGY	1,338	0	340	0	507
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,185	0	301	0	905
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	21,627	0	5,503	0	688
91.00	09100	EMERGENCY	12,839	851	3,266	0	3,131
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,215	0	818	0	3,384
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	164,528	8,210	40,429	73,490	22,441
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,764	0	958	0	5,918
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	FOUNDATION	835	0	213	0	127
193.02	19302	OCCUPATIONAL MEDICINE	516	0	131	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	169,643	8,210	41,731	73,490	28,486

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

Worksheet B
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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
13.00	01300	15,949					13.00
14.00	01400	0	51,543				14.00
16.00	01600	0	131	44,440			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,911	3,322	19,095	288,051	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,778	4,492	4,199	155,261	0	50.00
51.00	05100	330	109	0	17,089	0	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	2,915	5,084	226,346	0	54.00
55.00	05500	0	0	0	0	0	55.00
60.00	06000	0	20,345	0	128,710	0	60.00
65.00	06500	695	317	94	7,033	0	65.00
66.00	06600	0	691	0	94,725	0	66.00
67.00	06700	0	17	0	38,102	0	67.00
68.00	06800	0	85	0	2,542	0	68.00
69.00	06900	0	103	0	14,729	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	6,939	0	9,177	0	71.00
72.00	07200	0	3,186	0	4,115	0	72.00
73.00	07300	310	277	0	49,363	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	3,459	0	199,393	0	90.00
91.00	09100	5,925	3,334	15,968	158,488	0	91.00
92.00	09200					0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	1,680	0	44,833	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		15,949	51,402	44,440	1,437,957	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	100	0	34,241	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	7,229	0	193.01
193.02	19302	0	41	0	4,845	0	193.02
194.00	07950	0	0	0	0	0	194.00
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		15,949	51,543	44,440	1,484,272	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
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		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	288,051	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	155,261	50.00
51.00	05100 RECOVERY ROOM	17,089	51.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	226,346	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000 LABORATORY	128,710	60.00
65.00	06500 RESPIRATORY THERAPY	7,033	65.00
66.00	06600 PHYSICAL THERAPY	94,725	66.00
67.00	06700 OCCUPATIONAL THERAPY	38,102	67.00
68.00	06800 SPEECH PATHOLOGY	2,542	68.00
69.00	06900 ELECTROCARDIOLOGY	14,729	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,177	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4,115	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49,363	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	199,393	90.00
91.00	09100 EMERGENCY	158,488	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	44,833	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,437,957	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	34,241	192.00
193.00	19300 NONPAID WORKERS	0	193.00
193.01	19301 FOUNDATION	7,229	193.01
193.02	19302 OCCUPATIONAL MEDICINE	4,845	193.02
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,484,272	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00	5A	5.00	7.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	72,861					1.00	
4.00 00400 EMPLOYEE BENEFITS	666	10,426,098				4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	13,675	1,905,855	-3,293,684	15,206,382		5.00	
7.00 00700 OPERATION OF PLANT	7,542	190,302	0	852,424	50,978	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	296	0	0	64,679	296	8.00	
9.00 00900 HOUSEKEEPING	1,394	262,281	0	420,770	1,394	9.00	
10.00 01000 DIETARY	2,783	101,050	0	260,382	2,783	10.00	
11.00 01100 CAFETERIA	924	228,161	0	298,040	924	11.00	
13.00 01300 NURSING ADMINISTRATION	615	21,835	0	38,751	615	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	1,977	54,365	0	135,860	1,977	14.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,428	242,740	0	414,251	1,428	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	6,202	845,510	0	1,238,386	6,202	30.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	5,428	264,191	0	526,750	5,428	50.00	
51.00 05100 RECOVERY ROOM	628	32,728	0	54,707	628	51.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	7,586	764,432	0	1,513,863	7,586	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
60.00 06000 LABORATORY	3,187	547,786	0	1,457,895	3,187	60.00	
65.00 06500 RESPIRATORY THERAPY	131	88,250	0	117,146	131	65.00	
66.00 06600 PHYSICAL THERAPY	3,407	235,337	0	483,835	3,407	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,290	220,272	0	298,473	1,290	67.00	
68.00 06800 SPEECH PATHOLOGY	84	12,978	0	19,336	84	68.00	
69.00 06900 ELECTROCARDIOLOGY	402	167,884	0	218,275	402	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	121,070	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	50,268	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	356	321,208	0	2,094,649	356	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	6,499	2,524,184	0	1,755,049	6,499	90.00	
91.00 09100 EMERGENCY	3,858	739,523	0	1,818,969	3,858	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	966	583,840	0	827,650	966	95.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	71,324	10,354,712	-3,293,684	15,081,478	49,441	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1,131	100	0	24,953	1,131	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
193.01 19301 FOUNDATION	251	35,379	0	48,420	251	193.01	
193.02 19302 OCCUPATIONAL MEDICINE	155	35,907	0	51,531	155	193.02	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	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)	1,484,272	2,390,038		3,293,684	1,037,058	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20.371282	0.229236		0.216599	20.343246	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		13,567		281,058	169,643	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001301		0.018483	3.327769	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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

Worksheet B-1
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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	28,495					8.00
9.00	00900	2,000	49,288				9.00
10.00	01000	820	2,783	100			10.00
11.00	01100	0	924	0	1,574		11.00
13.00	01300	0	615	0	6	96,585	13.00
14.00	01400	0	1,977	0	24	0	14.00
16.00	01600	0	1,428	0	71	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,580	6,202	100	202	41,851	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,865	5,428	0	52	10,770	50.00
51.00	05100	0	628	0	10	1,998	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,205	7,586	0	156	0	54.00
55.00	05500	0	0	0	0	0	55.00
60.00	06000	0	3,187	0	137	0	60.00
65.00	06500	240	131	0	20	4,209	65.00
66.00	06600	561	3,407	0	55	0	66.00
67.00	06700	258	1,290	0	30	0	67.00
68.00	06800	11	84	0	1	0	68.00
69.00	06900	0	402	0	28	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	356	0	50	1,876	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	6,499	0	38	0	90.00
91.00	09100	2,955	3,858	0	173	35,881	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	966	0	187	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		28,495	47,751	100	1,240	96,585	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	1,131	0	327	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	251	0	7	0	193.01
193.02	19302	0	155	0	0	0	193.02
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		84,710	546,212	406,674	391,632	67,963	202.00
203.00		2.972802	11.082048	4,066.740000	248.813215	0.703660	203.00
204.00		8,210	41,731	73,490	28,486	15,949	204.00
205.00		0.288121	0.846677	734.900000	18.097840	0.165129	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
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
13.00	01300			13.00
14.00	01400	798,503		14.00
16.00	01600	2,036	94,400	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	51,458	40,560	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	69,595	8,920	50.00
51.00	05100	1,684	0	51.00
53.00	05300	0	0	53.00
54.00	05400	45,155	10,800	54.00
55.00	05500	0	0	55.00
60.00	06000	315,185	0	60.00
65.00	06500	4,917	200	65.00
66.00	06600	10,698	0	66.00
67.00	06700	263	0	67.00
68.00	06800	1,316	0	68.00
69.00	06900	1,602	0	69.00
70.00	07000	0	0	70.00
71.00	07100	107,494	0	71.00
72.00	07200	49,363	0	72.00
73.00	07300	4,289	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	53,585	0	90.00
91.00	09100	51,652	33,920	91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	26,028	0	95.00
SPECIAL PURPOSE COST CENTERS				
118.00		796,320	94,400	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	1,544	0	192.00
193.00	19300	0	0	193.00
193.01	19301	0	0	193.01
193.02	19302	639	0	193.02
194.00	07950	0	0	194.00
200.00				200.00
201.00				201.00
202.00		233,387	567,113	202.00
203.00		0.292281	6.007553	203.00
204.00		51,543	44,440	204.00
205.00		0.064550	0.470763	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

			Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Diallowance	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	2,501,842		2,501,842	0	0	2,512,116	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	911,408		911,408	0	0	117,267	50.00
51.00	05100 RECOVERY ROOM	90,678		90,678	0	0	9,324	51.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,200,633		2,200,633	0	0	759,635	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0		0	0	0	0	55.00
60.00	06000 LABORATORY	2,000,036		2,000,036	0	0	857,866	60.00
65.00	06500 RESPIRATORY THERAPY	157,927	0	157,927	0	0	239,987	65.00
66.00	06600 PHYSICAL THERAPY	714,179	0	714,179	0	0	199,351	66.00
67.00	06700 OCCUPATIONAL THERAPY	411,969	0	411,969	0	0	136,992	67.00
68.00	06800 SPEECH PATHOLOGY	26,831	0	26,831	0	0	15,591	68.00
69.00	06900 ELECTROCARDIOLOGY	285,621		285,621	0	0	189,533	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	178,712		178,712	0	0	130,093	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	75,584		75,584	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,574,548		2,574,548	0	0	990,992	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	2,364,541		2,364,541	0	0	0	90.00
91.00	09100 EMERGENCY	2,630,146		2,630,146	0	0	63,548	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	368,584		368,584	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES	1,091,410		1,091,410	0	0	0	95.00
200.00	Subtotal (see instructions)	18,584,649	0	18,584,649	0	0	6,222,295	200.00
201.00	Less Observation Beds	368,584		368,584		0		201.00
202.00	Total (see instructions)	18,216,065	0	18,216,065	0	0	6,222,295	202.00
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	Outpatient	Total (col. 6 + col. 7)						
	7.00	8.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	2,512,116						30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	2,211,336	2,328,603	0.391397	0.000000	0.000000		50.00
51.00	05100 RECOVERY ROOM	428,693	438,017	0.207019	0.000000	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,822,692	13,582,327	0.162022	0.000000	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0.000000		55.00
60.00	06000 LABORATORY	8,496,643	9,354,509	0.213804	0.000000	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	245,659	485,646	0.325190	0.000000	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	1,378,199	1,577,550	0.452714	0.000000	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	768,505	905,497	0.454965	0.000000	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	43,399	58,990	0.454840	0.000000	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	1,787,909	1,977,442	0.144440	0.000000	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,749,064	1,879,157	0.095102	0.000000	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	230,869	230,869	0.327389	0.000000	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,800,944	5,791,936	0.444506	0.000000	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	828,077	828,077	2.855460	0.000000	0.000000		90.00
91.00	09100 EMERGENCY	4,157,414	4,220,962	0.623115	0.000000	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	456,804	456,804	0.806876	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES	1,135,686	1,135,686	0.961014	0.000000	0.000000		95.00
200.00	Subtotal (see instructions)	41,541,893	47,764,188					200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	41,541,893	47,764,188					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	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		2,501,842		2,501,842	0	0	2,512,116	30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000 OPERATING ROOM		911,408		911,408	0	0	117,267	50.00
51.00	05100 RECOVERY ROOM		90,678		90,678	0	0	9,324	51.00
53.00	05300 ANESTHESIOLOGY		0		0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,200,633		2,200,633	0	0	759,635	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0		0	0	0	0	55.00
60.00	06000 LABORATORY		2,000,036		2,000,036	0	0	857,866	60.00
65.00	06500 RESPIRATORY THERAPY	0	157,927	0	157,927	0	0	239,987	65.00
66.00	06600 PHYSICAL THERAPY	0	714,179	0	714,179	0	0	199,351	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	411,969	0	411,969	0	0	136,992	67.00
68.00	06800 SPEECH PATHOLOGY	0	26,831	0	26,831	0	0	15,591	68.00
69.00	06900 ELECTROCARDIOLOGY		285,621		285,621	0	0	189,533	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		178,712		178,712	0	0	130,093	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		75,584		75,584	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,574,548		2,574,548	0	0	990,992	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000 CLINIC		2,364,541		2,364,541	0	0	0	90.00
91.00	09100 EMERGENCY		2,630,146		2,630,146	0	0	63,548	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		368,584		368,584	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500 AMBULANCE SERVICES		1,091,410		1,091,410	0	0	0	95.00
200.00	Subtotal (see instructions)	0	18,584,649	0	18,584,649	0	0	6,222,295	200.00
201.00	Less Observation Beds		368,584		368,584		0		201.00
202.00	Total (see instructions)	0	18,216,065	0	18,216,065	0	0	6,222,295	202.00
Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
	Outpatient	Total (col. 6 + col. 7)	9.00	10.00					11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000 ADULTS & PEDIATRICS		2,512,116						30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000 OPERATING ROOM		2,211,336	2,328,603	0.391397	0.000000	0.000000		50.00
51.00	05100 RECOVERY ROOM		428,693	438,017	0.207019	0.000000	0.000000		51.00
53.00	05300 ANESTHESIOLOGY		0	0	0.000000	0.000000	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		12,822,692	13,582,327	0.162022	0.000000	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0.000000	0.000000	0.000000		55.00
60.00	06000 LABORATORY		8,496,643	9,354,509	0.213804	0.000000	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY		245,659	485,646	0.325190	0.000000	0.000000		65.00
66.00	06600 PHYSICAL THERAPY		1,378,199	1,577,550	0.452714	0.000000	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY		768,505	905,497	0.454965	0.000000	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY		43,399	58,990	0.454840	0.000000	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY		1,787,909	1,977,442	0.144440	0.000000	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0.000000	0.000000	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,749,064	1,879,157	0.095102	0.000000	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		230,869	230,869	0.327389	0.000000	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,800,944	5,791,936	0.444506	0.000000	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000 CLINIC		828,077	828,077	2.855460	0.000000	0.000000		90.00
91.00	09100 EMERGENCY		4,157,414	4,220,962	0.623115	0.000000	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		456,804	456,804	0.806876	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500 AMBULANCE SERVICES		1,135,686	1,135,686	0.961014	0.000000	0.000000		95.00
200.00	Subtotal (see instructions)		41,541,893	47,764,188					200.00
201.00	Less Observation Beds								201.00
202.00	Total (see instructions)		41,541,893	47,764,188					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151304

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

Worksheet D
Part II
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	155,261	2,328,603	0.066676	57,365	3,825	50.00
51.00	05100 RECOVERY ROOM	17,089	438,017	0.039014	5,136	200	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	226,346	13,582,327	0.016665	397,746	6,628	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000 LABORATORY	128,710	9,354,509	0.013759	488,978	6,728	60.00
65.00	06500 RESPIRATORY THERAPY	7,033	485,646	0.014482	151,095	2,188	65.00
66.00	06600 PHYSICAL THERAPY	94,725	1,577,550	0.060046	57,084	3,428	66.00
67.00	06700 OCCUPATIONAL THERAPY	38,102	905,497	0.042079	42,287	1,779	67.00
68.00	06800 SPEECH PATHOLOGY	2,542	58,990	0.043092	10,265	442	68.00
69.00	06900 ELECTROCARDIOLOGY	14,729	1,977,442	0.007449	141,046	1,051	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,177	1,879,157	0.004884	45,672	223	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4,115	230,869	0.017824	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49,363	5,791,936	0.008523	532,742	4,541	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	199,393	828,077	0.240790	0	0	90.00
91.00	09100 EMERGENCY	158,488	4,220,962	0.037548	2,004	75	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	456,804	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,105,073	44,116,386		1,931,420	31,108	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO 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									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,328,603	0.000000	0.000000	57,365	50.00
51.00	05100	RECOVERY ROOM	0	438,017	0.000000	0.000000	5,136	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,582,327	0.000000	0.000000	397,746	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
60.00	06000	LABORATORY	0	9,354,509	0.000000	0.000000	488,978	60.00
65.00	06500	RESPIRATORY THERAPY	0	485,646	0.000000	0.000000	151,095	65.00
66.00	06600	PHYSICAL THERAPY	0	1,577,550	0.000000	0.000000	57,084	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	905,497	0.000000	0.000000	42,287	67.00
68.00	06800	SPEECH PATHOLOGY	0	58,990	0.000000	0.000000	10,265	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,977,442	0.000000	0.000000	141,046	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,879,157	0.000000	0.000000	45,672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	230,869	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,791,936	0.000000	0.000000	532,742	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	828,077	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,220,962	0.000000	0.000000	2,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	456,804	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	44,116,386			1,931,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/23/2013 2:38 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.391397	0	873,960	0	0
51.00 05100 RECOVERY ROOM	0.207019	0	120,414	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.162022	0	4,536,789	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.213804	0	3,045,908	0	0
65.00 06500 RESPIRATORY THERAPY	0.325190	0	77,645	0	0
66.00 06600 PHYSICAL THERAPY	0.452714	0	509,993	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.454965	0	247,861	0	0
68.00 06800 SPEECH PATHOLOGY	0.454840	0	16,504	0	0
69.00 06900 ELECTROCARDIOLOGY	0.144440	0	913,632	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095102	0	402,901	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.327389	0	47,356	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.444506	0	2,433,118	6,964	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	2.855460	0	188,054	0	0
91.00 09100 EMERGENCY	0.623115	0	1,009,322	5,809	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806876	0	446,174	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.961014	0	0	0	0
200.00 Subtotal (see instructions)		0	14,869,631	12,773	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	14,869,631	12,773	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/23/2013 2:38 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	342,065	0	50.00
51.00	05100 RECOVERY ROOM	24,928	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	735,060	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000 LABORATORY	651,227	0	60.00
65.00	06500 RESPIRATORY THERAPY	25,249	0	65.00
66.00	06600 PHYSICAL THERAPY	230,881	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	112,768	0	67.00
68.00	06800 SPEECH PATHOLOGY	7,507	0	68.00
69.00	06900 ELECTROCARDIOLOGY	131,965	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,317	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	15,504	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,081,536	3,096	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	536,981	0	90.00
91.00	09100 EMERGENCY	628,924	3,620	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	360,007	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	4,922,919	6,716	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	4,922,919	6,716	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304 Component CCN: 15Z304	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/23/2013 2:38 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)	
		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	0.391397	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.207019	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162022	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000 LABORATORY	0.213804	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.325190	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.452714	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.454965	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.454840	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144440	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095102	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.327389	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.444506	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2.855460	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.623115	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806876	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.961014		0			95.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304 Component CCN: 15Z304	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/23/2013 2:38 pm
Title XVII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII		Hospital
				Date/Time Prepared: 5/23/2013 2:38 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,682	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,044	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,656	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		579	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		59	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)		1,135	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)		554	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		171.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,501,842	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)		10,095	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)		560,122	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,941,720	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,512,116	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,512,116	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.772942	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)		1,516.98	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,941,720	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)		949.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,078,205	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)		1,078,205	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/23/2013 2:38 pm
Title XVIII			Hospital		Cost
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)					554,162 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,632,367 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					526,278 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)					526,278 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)					388 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					949.96 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					368,584 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/23/2013 2:38 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/23/2013 2:38 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,682	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,044	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,656	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		579	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		59	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)		105	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,501,842	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)		552,256	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,949,586	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,512,116	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,512,116	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.776073	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)		1,516.98	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,949,586	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)		953.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		100,150	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)		100,150	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/23/2013 2:38 pm
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				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)				80,619 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				180,769 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				388 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				953.81 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				370,078 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/23/2013 2:38 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/23/2013 2:38 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		1,236,454		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.391397	57,365	22,452	50.00
51.00	05100 RECOVERY ROOM	0.207019	5,136	1,063	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162022	397,746	64,444	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000 LABORATORY	0.213804	488,978	104,545	60.00
65.00	06500 RESPIRATORY THERAPY	0.325190	151,095	49,135	65.00
66.00	06600 PHYSICAL THERAPY	0.452714	57,084	25,843	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.454965	42,287	19,239	67.00
68.00	06800 SPEECH PATHOLOGY	0.454840	10,265	4,669	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144440	141,046	20,373	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095102	45,672	4,343	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.327389	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.444506	532,742	236,807	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.855460	0	0	90.00
91.00	09100 EMERGENCY	0.623115	2,004	1,249	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806876	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,931,420	554,162	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,931,420		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15Z304		Date/Time Prepared: 5/23/2013 2:38 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.391397	2,026	793	50.00
51.00	05100 RECOVERY ROOM	0.207019	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162022	36,583	5,927	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000 LABORATORY	0.213804	44,422	9,498	60.00
65.00	06500 RESPIRATORY THERAPY	0.325190	35,420	11,518	65.00
66.00	06600 PHYSICAL THERAPY	0.452714	108,312	49,034	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.454965	75,567	34,380	67.00
68.00	06800 SPEECH PATHOLOGY	0.454840	4,407	2,004	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144440	7,473	1,079	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095102	1,303	124	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.327389	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.444506	101,279	45,019	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.855460	0	0	90.00
91.00	09100 EMERGENCY	0.623115	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806876	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		416,792	159,376	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)		416,792		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/23/2013 2:38 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		149,795		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.391397	6,011	2,353	50.00
51.00	05100 RECOVERY ROOM	0.207019	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162022	73,878	11,970	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000 LABORATORY	0.213804	86,581	18,511	60.00
65.00	06500 RESPIRATORY THERAPY	0.325190	17,010	5,531	65.00
66.00	06600 PHYSICAL THERAPY	0.452714	847	383	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.454965	260	118	67.00
68.00	06800 SPEECH PATHOLOGY	0.454840	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.144440	5,909	853	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.095102	4,208	400	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.327389	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.444506	67,630	30,062	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.855460	0	0	90.00
91.00	09100 EMERGENCY	0.623115	16,751	10,438	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.806876	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		279,085	80,619	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		279,085		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/23/2013 2:38 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,929,635 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,929,635 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,978,931 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			28,831 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,328,813 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,621,287 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,621,287 30.00
31.00	Primary payer payments			837 31.00
32.00	Subtotal (line 30 minus line 31)			2,620,450 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)			237,481 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			237,481 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			118,871 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,857,931 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,857,931 40.00
41.00	Interim payments			2,585,326 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)			272,605 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,339,745		2,497,826	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/10/2012	117,200	08/10/2012	87,500	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)		117,200		87,500	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,456,945		2,585,326	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		272,605	6.01	
6.02	SETTLEMENT TO PROGRAM		76,710		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,380,235		2,857,931	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151304
Component CCN: 15Z304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2013 2:38 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		710,735		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/10/2012	30,100		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)		30,100		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)		740,835		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		55,260		0	6.02
7.00	Total Medicare program liability (see instructions)		685,575		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151304

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

Worksheet E-1
Part II
Date/Time Prepared:
5/23/2013 2:38 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			544 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,135 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			74 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,656 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			47,764,188 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			584,942 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			141,352 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			132,729 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			136,687 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			-3,958 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151304
Component CCN: 15Z304

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

Worksheet E-2
Date/Time Prepared:
5/23/2013 2:38 pm

		Title XVIII		Swing Beds - SNF	
		Cost			
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	531,541	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	160,970	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	554	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	692,511	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	692,511	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	692,511	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,936	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	685,575	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Reimbursable bad debts (see instructions)	0	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	685,575	0	19.00	
20.00	Interim payments	740,835	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-55,260	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/23/2013 2:38 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		1,632,367	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		1,632,367	4.00
5.00	Primary payer payments		1	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,648,690	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,648,690	19.00
20.00	Deductibles (exclude professional component)		304,028	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,344,662	22.00
23.00	Coinsurance		15,895	23.00
24.00	Subtotal (line 22 minus line 23)		1,328,767	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		51,468	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		51,468	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,742	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,380,235	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,380,235	30.00
31.00	Interim payments		1,456,945	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		-76,710	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2013 2:38 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		180,769		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		180,769	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		180,769	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		149,795		8.00
9.00	Ancillary service charges		279,085	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		428,880	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		428,880	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		248,111	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		180,769	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		180,769	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		180,769	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		180,769	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		180,769	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		180,769	0	40.00
41.00	Interim payments		297,011	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-116,242	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151304

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

Worksheet G

Date/Time Prepared:
5/23/2013 2:38 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	2,441,635	0	0	0	1.00
2.00	Temporary investments	13,835	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,228,891	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,257,343	0	0	0	6.00
7.00	Inventory	666,986	0	0	0	7.00
8.00	Prepaid expenses	225,182	0	0	0	8.00
9.00	Other current assets	252,792	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)	7,571,978	0	0	0	11.00
FIXED ASSETS						
12.00	Land	164,978	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	24,356,732	0	0	0	15.00
16.00	Accumulated depreciation	-15,218,616	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,303,094	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,875,072	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	943,249	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,688,783	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	580,174	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	663,286	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,875,492	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	3,298,727	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)	3,298,727	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,174,219	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,700,853				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,700,853	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,875,072	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151304

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

Worksheet G-1

Date/Time Prepared:
5/23/2013 2:38 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		9,363,984		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		336,869			2.00
3.00	Total (sum of line 1 and line 2)		9,700,853		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,700,853		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,700,853		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151304

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/23/2013 2:38 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,968,920		2,968,920	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,968,920		2,968,920	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,968,920		2,968,920	17.00
18.00	Ancillary services	3,646,629	34,963,912	38,610,541	18.00
19.00	Outpatient services	63,548	4,985,491	5,049,039	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	0	1,135,686	1,135,686	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	6,016,395	6,016,395	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,679,097	47,101,484	53,780,581	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,987,991		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)		22,987,991		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151304

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

Worksheet G-3

Date/Time Prepared:
5/23/2013 2:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,780,581	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,161,886	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,618,695	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,987,991	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,630,704	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,083,525	24.00
24.01	NON-OPERATING REVENUE	361,986	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	1,445,511	25.00
26.00	Total (line 5 plus line 25)	5,076,215	26.00
27.00	BAD DEBT EXPENSE	4,739,346	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,739,346	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	336,869	29.00