

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: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/31/2013 9:55 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/31/2013 Time: 9:55 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SCOTT MEMORIAL HOSPITAL (151334) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	55,808	-134,337	0	0	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	0	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	55,808	-134,337	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 9:48 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47170- County: SCOTT				
2.00 Street: 1451 NORTH GARDNER City: SCOTTSBURG		2.00 State: IN		3.00 Zip Code: 47170-		2.00 County: SCOTT				
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		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	SCOTT MEMORIAL HOSPITAL	151334	99915	1	07/01/1966	N	O	T	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)					9		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		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		25.00	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 9:48 am		
		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.	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151334

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

Worksheet S-2
Part I
Date/Time Prepared:
5/31/2013 9:48 am

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 9:48 am		
		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	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00		

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	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	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N	145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

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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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/31/2013 9:48 am	
			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.	N			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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/23/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151334

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

Worksheet S-2
Part II
Date/Time Prepared:
5/31/2013 9:48 am

	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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			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.			Y	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD		BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.581.0435		LV COSTREPORTS@BKD.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)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/23/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD	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: 151334

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2013 9:48 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,686	78,072.00	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)		21	7,686	78,072.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	7,728.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	85,800.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		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 Vi s i t s / Tri ps			Full Time Equivalents		
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,806	566	3,253			1.00
2.00 HMO	86	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,806	566	3,253			7.00
8.00 INTENSIVE CARE UNIT	167	51	322			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		290	349			13.00
14.00 Total (see instructions)	1,973	907	3,924	0.00	186.72	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151334

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2013 9:48 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	186.72	27.00
28.00	Observation Bed Days		0	834			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
		11.00	12.00	13.00	14.00		15.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	530	200	1,256	1.00
2.00	HMO			24			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	530	200	1,256	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/31/2013 9:48 am
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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)		0.352521	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,420,914	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?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		548,423	5.00
6.00	Medicaid charges		12,214,362	6.00
7.00	Medicaid cost (line 1 times line 6)		4,305,819	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)		336,482	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		336,482	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			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)		6,983,039	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		367,180	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		6,615,859	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,332,229	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,332,229	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,668,711	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151334

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

Worksheet A
Date/Time Prepared:
5/31/2013 9:48 am

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	0	0	1,033,188	1,033,188	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,460,997	-1,017,180	1,443,817	2.00
4.00	00400	EMPLOYEE BENEFITS	67,188	2,708,155	2,775,343	2,775,343	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,162,219	2,170,684	3,332,903	-69,143	3,263,760
7.00	00700	OPERATION OF PLANT	227,917	767,109	995,026	0	995,026
9.00	00900	HOUSEKEEPING	178,467	217,427	395,894	0	395,894
10.00	01000	DIETARY	192,630	304,666	497,296	-345,368	151,928
11.00	01100	CAFETERIA	0	0	0	345,368	345,368
13.00	01300	NURSING ADMINISTRATION	369,318	1,453	370,771	0	370,771
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	249,996	59,336	309,332	0	309,332
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,490,682	201,265	1,691,947	-140,899	1,551,048
31.00	03100	INTENSIVE CARE UNIT	269,138	2,408	271,546	0	271,546
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	119,960	119,960
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	743,231	578,507	1,321,738	-119,957	1,201,781
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	20,939	20,939
54.00	05400	RADIOLOGY-DIAGNOSTIC	671,495	1,368,962	2,040,457	-82,957	1,957,500
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	501,889	610,668	1,112,557	0	1,112,557
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	87,099	87,099	0	87,099
65.00	06500	RESPIRATORY THERAPY	427,125	54,200	481,325	-154,794	326,531
66.00	06600	PHYSICAL THERAPY	0	534,817	534,817	-203	534,614
69.00	06900	ELECTROCARDIOLOGY	0	0	0	154,794	154,794
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,720	301,909	375,629	13,907	389,536
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	119,957	119,957
73.00	07300	DRUGS CHARGED TO PATIENTS	153,426	613,880	767,306	82,957	850,263
76.00	03020	CARDIAC REHAB	51,567	9,076	60,643	0	60,643
76.01	03021	SLEEP LAB	0	19,711	19,711	0	19,711
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	849,959	633,076	1,483,035	0	1,483,035
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,679,967	13,705,405	21,385,372	-39,431	21,345,941
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PUBLIC RELATIONS	0	0	0	69,100	69,100
194.00	07951	BUHSE CAMPUS	244,770	125,358	370,128	-21,689	348,439
194.01	07950	MEDICAL SPECIALTY	22,397	10,026	32,423	-1	32,422
194.02	07952	MEDICAL OFFICE	0	11,941	11,941	0	11,941
194.03	07953	VA PROPERTY	0	42,660	42,660	0	42,660
194.04	07954	ARELFAI CAMPUS	422,677	76,978	499,655	-7,979	491,676
194.05	07955	ORTHO CAMPUS	41,582	463,716	505,298	0	505,298
200.00		TOTAL (SUM OF LINES 118-199)	8,411,393	14,436,084	22,847,477	0	22,847,477

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151334

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

Worksheet A
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
15.00	01500			15.00
16.00	01600			16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000			30.00
31.00	03100			31.00
41.00	04100			41.00
42.00	04200			42.00
43.00	04300			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000			50.00
52.00	05200			52.00
54.00	05400			54.00
57.00	05700			57.00
58.00	05800			58.00
59.00	05900			59.00
60.00	06000			60.00
60.01	06001			60.01
63.00	06300			63.00
65.00	06500			65.00
66.00	06600			66.00
69.00	06900			69.00
71.00	07100			71.00
72.00	07200			72.00
73.00	07300			73.00
76.00	03020			76.00
76.01	03021			76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800			88.00
89.00	08900			89.00
91.00	09100			91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900			109.00
110.00	11000			110.00
111.00	11100			111.00
113.00	11300			113.00
118.00				118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000			190.00
192.00	19200			192.00
192.01	19201			192.01
194.00	07951			194.00
194.01	07950			194.01
194.02	07952			194.02
194.03	07953			194.03
194.04	07954			194.04
194.05	07955			194.05
200.00				200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	133,780	211,588	1.00	
	TOTALS		133,780	211,588		
B - NURSERY - LD						
1.00	NURSERY	43.00	110,322	9,638	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	19,257	1,682	2.00	
	TOTALS		129,579	11,320		
C - EKG						
1.00	ELECTROCARDIOLOGY	69.00	137,363	17,431	1.00	
	TOTALS		137,363	17,431		
D - PUBLIC RELATIONS						
1.00	PUBLIC RELATIONS	192.01	24,840	44,260	1.00	
	TOTALS		24,840	44,260		
E - MEDICAL SUPPLIES						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	119,957	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,907	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	133,864		
F - CHARGEABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	82,957	1.00	
	TOTALS		0	82,957		
G - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,017,180	1.00	
	TOTALS		0	1,017,180		
H - SPG RENT						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	16,008	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	16,008		
500.00	Grand Total: Increases		425,562	1,534,608	500.00	

RECLASSIFICATIONS

Provider CCN: 151334

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

Worksheet A-6

Date/Time Prepared:
5/31/2013 9:48 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	133,780	211,588	0		1.00
	TOTALS		133,780	211,588			
B - NURSERY - LD							
1.00	ADULTS & PEDIATRICS	30.00	129,579	11,320	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		129,579	11,320			
C - EKG							
1.00	RESPIRATORY THERAPY	65.00	137,363	17,431	0		1.00
	TOTALS		137,363	17,431			
D - PUBLIC RELATIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	24,840	44,260	0		1.00
	TOTALS		24,840	44,260			
E - MEDICAL SUPPLIES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43	0		1.00
2.00	OPERATING ROOM	50.00	0	119,957	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	203	0		3.00
4.00	BUHSE CAMPUS	194.00	0	13,660	0		4.00
5.00	MEDICAL SPECIALTY	194.01	0	1	0		5.00
	TOTALS		0	133,864			
F - CHARGEABLE DRUGS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,957	0		1.00
	TOTALS		0	82,957			
G - DEPRECIATION							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,017,180	9		1.00
	TOTALS		0	1,017,180			
H - SPG RENT							
1.00	BUHSE CAMPUS	194.00	0	8,029	14		1.00
2.00	ARELFAI CAMPUS	194.04	0	7,979	0		2.00
	TOTALS		0	16,008			
500.00	Grand Total: Decreases		425,562	1,534,608			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

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

Worksheet A-7
Part I
Date/Time Prepared:
5/31/2013 9:48 am

	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	241,233	0	0	0	1.00
2.00	Land Improvements	520,508	0	0	0	2.00
3.00	Buildings and Fixtures	18,977,955	3,898,903	0	3,898,903	3.00
4.00	Building Improvements	41,213	0	0	51,213	4.00
5.00	Fixed Equipment	2,405,254	40,435	0	40,435	5.00
6.00	Movable Equipment	14,703,974	170,625	0	170,625	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,890,137	4,109,963	0	4,109,963	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,890,137	4,109,963	0	4,109,963	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	241,233	0			1.00
2.00	Land Improvements	520,508	0			2.00
3.00	Buildings and Fixtures	22,876,858	0			3.00
4.00	Building Improvements	-10,000	0			4.00
5.00	Fixed Equipment	2,445,689	0			5.00
6.00	Movable Equipment	14,874,599	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	40,948,887	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	40,948,887	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

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

Worksheet A-7
Part II
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,460,997	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,460,997	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,460,997				2.00
3.00	Total (sum of lines 1-2)	0	2,460,997				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

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

Worksheet A-7
Part III
Date/Time Prepared:
5/31/2013 9:48 am

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	26,074,288	0	26,074,288	0.636752	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	14,874,599	0	14,874,599	0.363248	0	2.00
3.00	Total (sum of lines 1-2)	40,948,887	0	40,948,887	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	1,017,180	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,443,817	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,460,997	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	16,008	1,033,188	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,443,817	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,008	2,477,005	3.00

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 #		
			3.00	4.00		
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-7,994	ADMINISTRATIVE & GENERAL	5.00	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	-1,118,310			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	B	-84,331	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-1,930	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-12,571	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 OTHER MISCELLANEOUS INCOME	B	-20,945	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 IHA & AHA DUES	A	-697	ADMINISTRATIVE & GENERAL	5.00	0	34.00

Provider CCN: 151334

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

Worksheet A-8

Date/Time Prepared:
 5/31/2013 9:48 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
35.00	PHYSICIAN RECRUITMENT	A	-10,582	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,257,360				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151334

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2013 9:48 am

	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	54.00	RADIOLOGY-DIAGNOSTIC	720,000	720,000	0	0	0	1.00
2.00	50.00	OPERATING ROOM	398,310	398,310	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,118,310	1,118,310	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	720,000	1.00
2.00	50.00	OPERATING ROOM	0	0	0	398,310	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,118,310	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2013 9:48 am	
		Physical Therapy				Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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	1,682.75	5,452.00	269.75	1,521.00	0.00	9.00
10.00	AHSEA (see instructions)	84.74	73.69	55.27	41.45	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	27.64			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	0	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)					142,596	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					401,758	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					14,909	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					559,263	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					63,045	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)					622,308	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)					622,308	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)					0	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)					0	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)					0	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)					0	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: 151334				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2013 9:48 am	
		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		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)	73.69	55.27	41.45	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)					622,308		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		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)					622,308		63.00	
64.00	Total cost of outside supplier services (from your records)					498,889		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					0		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					0		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	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2013 9:48 am	
		Speech Pathology		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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	404.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	77.21	67.14	50.36	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	25.18			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	0	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)					27,158	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)					27,158	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)					27,158	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)					67.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,369	22.00
23.00	Total salary equivalency (see instructions)					52,369	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)					0	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)					0	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)					0	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)					0	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: 151334				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2013 9:48 am	
		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	50.36	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)					52,369		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0		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)					52,369		63.00	
64.00	Total cost of outside supplier services (from your records)					16,654		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					0		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					0		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: 151334

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

Worksheet B Part I Date/Time Prepared: 5/31/2013 9:48 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,033,188	1,033,188			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,443,817		1,443,817		2.00
4.00 00400	EMPLOYEE BENEFITS	2,775,343	0	0	2,775,343	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,223,542	121,351	214,579	378,300	5.00
7.00 00700	OPERATION OF PLANT	995,026	17,177	30,373	75,807	7.00
9.00 00900	HOUSEKEEPING	395,894	7,648	13,524	59,359	9.00
10.00 01000	DIETARY	151,928	16,832	29,763	19,574	10.00
11.00 01100	CAFETERIA	261,037	17,992	31,814	44,496	11.00
13.00 01300	NURSING ADMINISTRATION	370,771	0	0	122,838	13.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	296,761	13,000	22,988	83,150	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,551,048	133,598	236,237	452,715	30.00
31.00 03100	INTENSIVE CARE UNIT	271,546	6,363	11,251	89,517	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	119,960	1,763	3,118	36,694	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	803,471	176,911	312,821	247,204	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	20,939	5,783	10,226	6,405	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,237,500	57,627	101,900	223,344	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,112,557	20,225	35,763	166,932	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	87,099	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	326,531	26,964	47,680	96,377	65.00
66.00 06600	PHYSICAL THERAPY	534,614	27,427	48,497	0	66.00
69.00 06900	ELECTROCARDIOLOGY	154,794	0	0	45,688	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	389,536	14,105	24,941	24,520	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	119,957	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	848,333	3,761	6,651	51,031	73.00
76.00 03020	CARDIAC REHAB	60,643	6,018	10,642	17,152	76.00
76.01 03021	SLEEP LAB	19,711	6,394	11,307	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	1,483,035	58,677	103,756	282,702	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	20,088,581	739,616	1,307,831	2,523,805	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,203	9,201	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	PUBLIC RELATIONS	69,100	0	0	8,262	192.01
194.00 07951	BUHSE CAMPUS	348,439	9,482	16,766	81,412	194.00
194.01 07950	MEDICAL SPECIALTY	32,422	18,963	33,532	7,449	194.01
194.02 07952	MEDICAL OFFICE	11,941	138,308	0	0	194.02
194.03 07953	VA PROPERTY	42,660	78,361	0	0	194.03
194.04 07954	ARELFAI CAMPUS	491,676	27,583	48,774	140,585	194.04
194.05 07955	ORTHO CAMPUS	505,298	15,672	27,713	13,830	194.05
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	21,590,117	1,033,188	1,443,817	2,775,343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

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

Worksheet B Part I Date/Time Prepared: 5/31/2013 9:48 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,937,772				5.00
7.00	00700	OPERATION OF PLANT	282,142	1,400,525			7.00
9.00	00900	HOUSEKEEPING	120,191	11,973	608,589		9.00
10.00	01000	DIETARY	55,021	26,349	0	299,467	10.00
11.00	01100	CAFETERIA	89,644	28,165	15,897	0	489,045
13.00	01300	NURSING ADMINISTRATION	124,526	0	0	0	21,717
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	104,922	20,351	10,713	0	30,116
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	598,799	209,138	125,106	278,500	127,130
31.00	03100	INTENSIVE CARE UNIT	95,531	9,961	21,772	20,967	17,599
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	40,752	2,760	15,897	0	9,774
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	388,609	276,937	110,590	0	31,415
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,937	9,053	43,199	0	1,699
54.00	05400	RADIOLOGY-DIAGNOSTIC	408,782	90,211	36,633	0	49,092
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	336,910	31,661	26,956	0	48,429
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,973	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	125,521	42,210	13,133	0	24,320
66.00	06600	PHYSICAL THERAPY	154,025	42,934	16,588	0	16,532
69.00	06900	ELECTROCARDIOLOGY	50,577	0	13,824	0	11,532
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,307	22,080	0	0	11,289
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	30,262	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	229,516	5,888	7,257	0	9,122
76.00	03020	CARDIAC REHAB	23,829	9,421	5,529	0	5,133
76.01	03021	SLEEP LAB	9,438	10,010	10,368	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	486,433	91,855	112,318	0	71,720
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,902,647	940,957	585,780	299,467	486,619
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,634	8,145	6,221	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PUBLIC RELATIONS	19,517	0	0	0	2,426
194.00	07951	BUHSE CAMPUS	1,622	14,843	0	0	0
194.01	07950	MEDICAL SPECIALTY	1,622	29,686	16,588	0	0
194.02	07952	MEDICAL OFFICE	1,456	216,511	0	0	0
194.03	07953	VA PROPERTY	1,456	122,669	0	0	0
194.04	07954	ARELFAL CAMPUS	2,548	43,180	0	0	0
194.05	07955	ORTHO CAMPUS	3,270	24,534	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,937,772	1,400,525	608,589	299,467	489,045

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

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

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Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	639,852				13.00
15.00	01500	PHARMACY	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	582,001		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	319,926	0	22,318	4,054,515	0 30.00
31.00	03100	INTENSIVE CARE UNIT	28,094	0	3,267	575,868	0 31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	2,531	233,249	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	86,288	0	45,214	2,479,460	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,851	113,092	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	163,355	2,368,444	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	116,754	1,896,187	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	908	109,980	0 63.00
65.00	06500	RESPIRATORY THERAPY	0	0	23,201	725,937	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	24,798	865,415	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14,029	290,444	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25,547	626,325	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,171	152,390	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	49,996	1,211,555	0 73.00
76.00	03020	CARDIAC REHAB	76,828	0	1,572	216,767	0 76.00
76.01	03021	SLEEP LAB	0	0	10,686	77,914	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	128,716	0	70,803	2,890,015	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	639,852	0	582,001	18,887,557	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	32,404	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	19201	PUBLIC RELATIONS	0	0	0	99,305	0 192.01
194.00	07951	BUHSE CAMPUS	0	0	0	472,564	0 194.00
194.01	07950	MEDICAL SPECIALTY	0	0	0	140,262	0 194.01
194.02	07952	MEDICAL OFFICE	0	0	0	368,216	0 194.02
194.03	07953	VA PROPERTY	0	0	0	245,146	0 194.03
194.04	07954	ARELFAI CAMPUS	0	0	0	754,346	0 194.04
194.05	07955	ORTHO CAMPUS	0	0	0	590,317	0 194.05
200.00		Cross Foot Adjustments	0	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	639,852	0	582,001	21,590,117	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

Period:
From 01/01/2012
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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
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
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
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	4,054,515	30.00
31.00	03100 INTENSIVE CARE UNIT	575,868	31.00
41.00	04100 SUBPROVIDER - I RF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	233,249	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	2,479,460	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	113,092	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,368,444	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	1,896,187	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	109,980	63.00
65.00	06500 RESPIRATORY THERAPY	725,937	65.00
66.00	06600 PHYSICAL THERAPY	865,415	66.00
69.00	06900 ELECTROCARDIOLOGY	290,444	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	626,325	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	152,390	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,211,555	73.00
76.00	03020 CARDIAC REHAB	216,767	76.00
76.01	03021 SLEEP LAB	77,914	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100 EMERGENCY	2,890,015	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,887,557	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,404	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 PUBLIC RELATIONS	99,305	192.01
194.00	07951 BUHSE CAMPUS	472,564	194.00
194.01	07950 MEDICAL SPECIALTY	140,262	194.01
194.02	07952 MEDICAL OFFICE	368,216	194.02
194.03	07953 VA PROPERTY	245,146	194.03
194.04	07954 ARELFAI CAMPUS	754,346	194.04
194.05	07955 ORTHO CAMPUS	590,317	194.05
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	21,590,117	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B Part II Date/Time Prepared: 5/31/2013 9:48 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	121,351	214,579	335,930	5.00
7.00 00700	OPERATION OF PLANT	0	17,177	30,373	47,550	7.00
9.00 00900	HOUSEKEEPING	0	7,648	13,524	21,172	9.00
10.00 01000	DIETARY	0	16,832	29,763	46,595	10.00
11.00 01100	CAFETERIA	0	17,992	31,814	49,806	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	13,000	22,988	35,988	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	133,598	236,237	369,835	30.00
31.00 03100	INTENSIVE CARE UNIT	0	6,363	11,251	17,614	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	1,763	3,118	4,881	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	176,911	312,821	489,732	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	5,783	10,226	16,009	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	57,627	101,900	159,527	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	20,225	35,763	55,988	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	0	26,964	47,680	74,644	65.00
66.00 06600	PHYSICAL THERAPY	0	27,427	48,497	75,924	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,105	24,941	39,046	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	3,761	6,651	10,412	73.00
76.00 03020	CARDIAC REHAB	0	6,018	10,642	16,660	76.00
76.01 03021	SLEEP LAB	0	6,394	11,307	17,701	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	58,677	103,756	162,433	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	739,616	1,307,831	2,047,447	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,203	9,201	14,404	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	PUBLIC RELATIONS	0	0	0	0	192.01
194.00 07951	BUHSE CAMPUS	0	9,482	16,766	26,248	194.00
194.01 07950	MEDICAL SPECIALTY	0	18,963	33,532	52,495	194.01
194.02 07952	MEDICAL OFFICE	0	138,308	0	138,308	194.02
194.03 07953	VA PROPERTY	0	78,361	0	78,361	194.03
194.04 07954	ARELFAI CAMPUS	0	27,583	48,774	76,357	194.04
194.05 07955	ORTHO CAMPUS	0	15,672	27,713	43,385	194.05
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,033,188	1,443,817	2,477,005	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	335,930				5.00
7.00	00700	OPERATION OF PLANT	24,070	71,620			7.00
9.00	00900	HOUSEKEEPING	10,254	612	32,038		9.00
10.00	01000	DIETARY	4,694	1,347	0	52,636	10.00
11.00	01100	CAFETERIA	7,648	1,440	837	0	59,731
13.00	01300	NURSING ADMINISTRATION	10,623	0	0	0	2,652
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	8,951	1,041	564	0	3,678
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	51,078	10,695	6,587	48,951	15,528
31.00	03100	INTENSIVE CARE UNIT	8,150	509	1,146	3,685	2,150
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,477	141	837	0	1,194
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,153	14,162	5,822	0	3,837
52.00	05200	DELIVERY ROOM & LABOR ROOM	933	463	2,274	0	208
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,874	4,613	1,928	0	5,996
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	28,742	1,619	1,419	0	5,915
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,875	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	10,708	2,159	691	0	2,970
66.00	06600	PHYSICAL THERAPY	13,140	2,196	873	0	2,019
69.00	06900	ELECTROCARDIOLOGY	4,315	0	728	0	1,408
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,752	1,129	0	0	1,379
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,582	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	19,580	301	382	0	1,114
76.00	03020	CARDIAC REHAB	2,033	482	291	0	627
76.01	03021	SLEEP LAB	805	512	546	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	41,498	4,697	5,913	0	8,760
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	332,935	48,118	30,838	52,636	59,435
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	310	417	327	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PUBLIC RELATIONS	1,665	0	0	0	296
194.00	07951	BUHSE CAMPUS	138	759	0	0	0
194.01	07950	MEDICAL SPECIALTY	138	1,518	873	0	0
194.02	07952	MEDICAL OFFICE	124	11,072	0	0	0
194.03	07953	VA PROPERTY	124	6,273	0	0	0
194.04	07954	ARELFAI CAMPUS	217	2,208	0	0	0
194.05	07955	ORTHO CAMPUS	279	1,255	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	335,930	71,620	32,038	52,636	59,731

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	13,275				13.00
15.00	01500	PHARMACY	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	50,222		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,638	0	1,925	511,237	0 30.00
31.00	03100	INTENSIVE CARE UNIT	583	0	282	34,119	0 31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	218	10,748	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,790	0	3,900	552,396	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	418	20,305	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,112	221,050	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	10,071	103,754	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	78	1,953	0 63.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,001	93,173	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,139	96,291	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,210	7,661	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,204	53,510	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	187	2,769	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,312	36,101	0 73.00
76.00	03020	CARDIAC REHAB	1,594	0	136	21,823	0 76.00
76.01	03021	SLEEP LAB	0	0	922	20,486	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	2,670	0	6,107	232,078	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,275	0	50,222	2,019,454	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,458	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	19201	PUBLIC RELATIONS	0	0	0	1,961	0 192.01
194.00	07951	BUHSE CAMPUS	0	0	0	27,145	0 194.00
194.01	07950	MEDICAL SPECIALTY	0	0	0	55,024	0 194.01
194.02	07952	MEDICAL OFFICE	0	0	0	149,504	0 194.02
194.03	07953	VA PROPERTY	0	0	0	84,758	0 194.03
194.04	07954	ARELFAI CAMPUS	0	0	0	78,782	0 194.04
194.05	07955	ORTHO CAMPUS	0	0	0	44,919	0 194.05
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)	13,275	0	50,222	2,477,005	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/31/2013 9:48 am
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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
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
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
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	511,237	30.00
31.00	03100 INTENSIVE CARE UNIT	34,119	31.00
41.00	04100 SUBPROVIDER - I RF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	10,748	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	552,396	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20,305	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	221,050	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	103,754	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,953	63.00
65.00	06500 RESPIRATORY THERAPY	93,173	65.00
66.00	06600 PHYSICAL THERAPY	96,291	66.00
69.00	06900 ELECTROCARDIOLOGY	7,661	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53,510	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,769	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	36,101	73.00
76.00	03020 CARDIAC REHAB	21,823	76.00
76.01	03021 SLEEP LAB	20,486	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100 EMERGENCY	232,078	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,019,454	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,458	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 PUBLIC RELATIONS	1,961	192.01
194.00	07951 BUHSE CAMPUS	27,145	194.00
194.01	07950 MEDICAL SPECIALTY	55,024	194.01
194.02	07952 MEDICAL OFFICE	149,504	194.02
194.03	07953 VA PROPERTY	84,758	194.03
194.04	07954 ARELFAI CAMPUS	78,782	194.04
194.05	07955 ORTHO CAMPUS	44,919	194.05
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,477,005	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

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

Worksheet B-1
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	131,849					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		104,199				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	8,344,205			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,486	15,486	1,137,379	-3,937,772	15,608,940	5.00
7.00 00700	OPERATION OF PLANT	2,192	2,192	227,917	0	1,118,383	7.00
9.00 00900	HOUSEKEEPING	976	976	178,467	0	476,425	9.00
10.00 01000	DIETARY	2,148	2,148	58,850	0	218,097	10.00
11.00 01100	CAFETERIA	2,296	2,296	133,780	0	355,339	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	369,318	0	493,609	13.00
15.00 01500	PHARMACY	0	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,659	1,659	249,996	0	415,899	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	17,049	17,049	1,361,103	0	2,373,598	30.00
31.00 03100	INTENSIVE CARE UNIT	812	812	269,138	0	378,677	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	225	225	110,322	0	161,535	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	22,576	22,576	743,231	0	1,540,407	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	738	738	19,257	0	43,353	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,354	7,354	671,495	0	1,620,371	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,581	2,581	501,889	0	1,335,477	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	87,099	63.00
65.00 06500	RESPIRATORY THERAPY	3,441	3,441	289,762	0	497,552	65.00
66.00 06600	PHYSICAL THERAPY	3,500	3,500	0	0	610,538	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	137,363	0	200,482	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,800	1,800	73,720	0	453,102	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	119,957	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	480	480	153,426	0	909,776	73.00
76.00 03020	CARDIAC REHAB	768	768	51,567	0	94,455	76.00
76.01 03021	SLEEP LAB	816	816	0	0	37,412	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	7,488	7,488	849,959	0	1,928,170	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	94,385	94,385	7,587,939	-3,937,772	15,469,713	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	664	0	0	14,404	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	PUBLIC RELATIONS	0	0	24,840	0	77,362	192.01
194.00 07951	BUHSE CAMPUS	1,210	1,210	244,770	-449,671	6,428	194.00
194.01 07950	MEDICAL SPECIALTY	2,420	2,420	22,397	-85,938	6,428	194.01
194.02 07952	MEDICAL OFFICE	17,650	0	0	-144,477	5,772	194.02
194.03 07953	VA PROPERTY	10,000	0	0	-115,249	5,772	194.03
194.04 07954	ARELFAI CAMPUS	3,520	3,520	422,677	-698,517	10,101	194.04
194.05 07955	ORTHO CAMPUS	2,000	2,000	41,582	-549,553	12,960	194.05
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)	1,033,188	1,443,817	2,775,343		3,937,772	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.836146	13.856342	0.332607		0.252277	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		335,930	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.021522	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

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

Worksheet B-1
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (HOURS SUPERVISED)	
		7.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	114,171				7.00
9.00	00900	HOUSEKEEPING	976	1,761			9.00
10.00	01000	DIETARY	2,148	0	13,897		10.00
11.00	01100	CAFETERIA	2,296	46	0	275,991	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	12,256	2,232
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,659	31	0	16,996	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,049	362	12,924	71,744	1,116
31.00	03100	INTENSIVE CARE UNIT	812	63	973	9,932	98
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	225	46	0	5,516	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,576	320	0	17,729	301
52.00	05200	DELIVERY ROOM & LABOR ROOM	738	125	0	959	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,354	106	0	27,705	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,581	78	0	27,331	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,441	38	0	13,725	0
66.00	06600	PHYSICAL THERAPY	3,500	48	0	9,330	0
69.00	06900	ELECTROCARDIOLOGY	0	40	0	6,508	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,800	0	0	6,371	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	480	21	0	5,148	0
76.00	03020	CARDIAC REHAB	768	16	0	2,897	268
76.01	03021	SLEEP LAB	816	30	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	7,488	325	0	40,475	449
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,707	1,695	13,897	274,622	2,232
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	18	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	PUBLIC RELATIONS	0	0	0	1,369	0
194.00	07951	BUHSE CAMPUS	1,210	0	0	0	0
194.01	07950	MEDICAL SPECIALTY	2,420	48	0	0	0
194.02	07952	MEDICAL OFFICE	17,650	0	0	0	0
194.03	07953	VA PROPERTY	10,000	0	0	0	0
194.04	07954	ARELFAI CAMPUS	3,520	0	0	0	0
194.05	07955	ORTHO CAMPUS	2,000	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,400,525	608,589	299,467	489,045	639,852
203.00		Unit cost multiplier (Wkst. B, Part I)	12.266907	345.592845	21.549039	1.771960	286.672043
204.00		Cost to be allocated (per Wkst. B, Part II)	71,620	32,038	52,636	59,731	13,275
205.00		Unit cost multiplier (Wkst. B, Part II)	0.627305	18.193072	3.787580	0.216424	5.947581

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

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

Worksheet B-1

Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		15.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
15.00	01500	100		15.00
16.00	01600	0	53,578,589	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	2,054,490	30.00
31.00	03100	0	300,746	31.00
41.00	04100	0	0	41.00
42.00	04200	0	0	42.00
43.00	04300	0	233,009	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	4,162,232	50.00
52.00	05200	0	446,526	52.00
54.00	05400	0	15,039,845	54.00
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
59.00	05900	0	0	59.00
60.00	06000	0	10,747,819	60.00
60.01	06001	0	0	60.01
63.00	06300	0	83,628	63.00
65.00	06500	0	2,135,826	65.00
66.00	06600	0	2,282,766	66.00
69.00	06900	0	1,291,467	69.00
71.00	07100	0	2,351,775	71.00
72.00	07200	0	199,818	72.00
73.00	07300	100	4,602,441	73.00
76.00	03020	0	144,714	76.00
76.01	03021	0	983,682	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	0	0	88.00
89.00	08900	0	0	89.00
91.00	09100	0	6,517,805	91.00
92.00	09200	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	0	0	109.00
110.00	11000	0	0	110.00
111.00	11100	0	0	111.00
113.00	11300	0	0	113.00
118.00		100	53,578,589	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
192.01	19201	0	0	192.01
194.00	07951	0	0	194.00
194.01	07950	0	0	194.01
194.02	07952	0	0	194.02
194.03	07953	0	0	194.03
194.04	07954	0	0	194.04
194.05	07955	0	0	194.05
200.00				200.00
201.00				201.00
202.00		0	582,001	202.00
203.00		0.000000	0.010863	203.00
204.00		0	50,222	204.00
205.00		0.000000	0.000937	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C Part I Date/Time Prepared: 5/31/2013 9:48 am

			Title XVIII		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,054,515		4,054,515	0	0	1,476,163	30.00
31.00	03100	INTENSIVE CARE UNIT	575,868		575,868	0	0	300,746	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	233,249		233,249	0	0	233,009	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,479,460		2,479,460	0	0	1,293,838	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,092		113,092	0	0	166,244	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368,444		2,368,444	0	0	1,115,226	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	1,896,187		1,896,187	0	0	2,280,197	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	109,980		109,980	0	0	45,947	63.00
65.00	06500	RESPIRATORY THERAPY	725,937	0	725,937	0	0	868,281	65.00
66.00	06600	PHYSICAL THERAPY	865,415	0	865,415	0	0	86,085	66.00
69.00	06900	ELECTROCARDIOLOGY	290,444		290,444	0	0	461,723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	626,325		626,325	0	0	938,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	152,390		152,390	0	0	127,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,555		1,211,555	0	0	2,095,122	73.00
76.00	03020	CARDIAC REHAB	216,767		216,767	0	0	179	76.00
76.01	03021	SLEEP LAB	77,914		77,914	0	0	2,696	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00	09100	EMERGENCY	2,890,015		2,890,015	0	0	593,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	827,370		827,370	0	0	90,489	92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	0	113.00
200.00		Subtotal (see instructions)	19,714,927	0	19,714,927	0	0	12,174,301	200.00
201.00		Less Observation Beds	827,370		827,370	0	0	0	201.00
202.00		Total (see instructions)	18,887,557	0	18,887,557	0	0	12,174,301	202.00
Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			Outpatient	Total (col. 6 + col. 7)					9.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		1,476,163					30.00
31.00	03100	INTENSIVE CARE UNIT		300,746					31.00
41.00	04100	SUBPROVIDER - IRF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		233,009					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,868,394	4,162,232	0.595704	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	280,282	446,526	0.253271	0.000000	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,924,619	15,039,845	0.157478	0.000000	0.000000		54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00
60.00	06000	LABORATORY	8,467,622	10,747,819	0.176425	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital	Cost
			Outpatient	Total (col. 6 + col. 7)					
			7.00	8.00	9.00	10.00	11.00		
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	37,681	83,628	1.315110	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	1,267,545	2,135,826	0.339886	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,196,681	2,282,766	0.379108	0.000000	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	829,744	1,291,467	0.224895	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,413,525	2,351,775	0.266320	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72,780	199,818	0.762644	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,507,319	4,602,441	0.263242	0.000000	0.000000		73.00
76.00	03020	CARDIAC REHAB	144,535	144,714	1.497899	0.000000	0.000000		76.00
76.01	03021	SLEEP LAB	980,986	983,682	0.079206	0.000000	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
91.00	09100	EMERGENCY	5,924,737	6,517,805	0.443403	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	487,838	578,327	1.430627	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0					99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0	0					110.00
111.00	11100	ISLET ACQUISITION	0	0					111.00
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	41,404,288	53,578,589					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	41,404,288	53,578,589					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 9:48 am

			Title XIX		Hospital		Tefra		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			3.00	4.00	5.00	6.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,054,515		4,054,515	0	0	1,476,163	30.00
31.00	03100	INTENSIVE CARE UNIT	575,868		575,868	0	0	300,746	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	233,249		233,249	0	0	233,009	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,479,460		2,479,460	0	0	1,293,838	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,092		113,092	0	0	166,244	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368,444		2,368,444	0	0	1,115,226	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	1,896,187		1,896,187	0	0	2,280,197	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	109,980		109,980	0	0	45,947	63.00
65.00	06500	RESPIRATORY THERAPY	725,937	0	725,937	0	0	868,281	65.00
66.00	06600	PHYSICAL THERAPY	865,415	0	865,415	0	0	86,085	66.00
69.00	06900	ELECTROCARDIOLOGY	290,444		290,444	0	0	461,723	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	626,325		626,325	0	0	938,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	152,390		152,390	0	0	127,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,555		1,211,555	0	0	2,095,122	73.00
76.00	03020	CARDIAC REHAB	216,767		216,767	0	0	179	76.00
76.01	03021	SLEEP LAB	77,914		77,914	0	0	2,696	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00	09100	EMERGENCY	2,890,015		2,890,015	0	0	593,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	827,370		827,370	0	0	90,489	92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	0	113.00
200.00		Subtotal (see instructions)	19,714,927	0	19,714,927	0	0	12,174,301	200.00
201.00		Less Observation Beds	827,370		827,370	0	0	0	201.00
202.00		Total (see instructions)	18,887,557	0	18,887,557	0	0	12,174,301	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							
9.00	10.00	11.00							
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		1,476,163					30.00
31.00	03100	INTENSIVE CARE UNIT		300,746					31.00
41.00	04100	SUBPROVIDER - IRF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		233,009					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,868,394	4,162,232	0.595704	0.595704	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	280,282	446,526	0.253271	0.253271	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,924,619	15,039,845	0.157478	0.157478	0.000000		54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00
60.00	06000	LABORATORY	8,467,622	10,747,819	0.176425	0.176425	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Tefra	
			Outpatient	Total (col. 6 + col. 7)					
			7.00	8.00	9.00	10.00	11.00		
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	37,681	83,628	1.315110	1.315110	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	1,267,545	2,135,826	0.339886	0.339886	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,196,681	2,282,766	0.379108	0.379108	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	829,744	1,291,467	0.224895	0.224895	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,413,525	2,351,775	0.266320	0.266320	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72,780	199,818	0.762644	0.762644	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,507,319	4,602,441	0.263242	0.263242	0.000000		73.00
76.00	03020	CARDIAC REHAB	144,535	144,714	1.497899	1.497899	0.000000		76.00
76.01	03021	SLEEP LAB	980,986	983,682	0.079206	0.079206	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0.000000		89.00
91.00	09100	EMERGENCY	5,924,737	6,517,805	0.443403	0.443403	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	487,838	578,327	1.430627	1.430627	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0					99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0	0					110.00
111.00	11100	ISLET ACQUISITION	0	0					111.00
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	41,404,288	53,578,589					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	41,404,288	53,578,589					202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151334

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

Worksheet C Part II Date/Time Prepared: 5/31/2013 9:48 am

Cost Center Description		Title XIX			Hospital	Tefra		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,479,460	552,396	1,927,064	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	113,092	20,305	92,787	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368,444	221,050	2,147,394	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,896,187	103,754	1,792,433	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	109,980	1,953	108,027	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	725,937	93,173	632,764	0	0	65.00
66.00	06600	PHYSICAL THERAPY	865,415	96,291	769,124	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	290,444	7,661	282,783	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	626,325	53,510	572,815	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	152,390	2,769	149,621	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,555	36,101	1,175,454	0	0	73.00
76.00	03020	CARDIAC REHAB	216,767	21,823	194,944	0	0	76.00
76.01	03021	SLEEP LAB	77,914	20,486	57,428	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,890,015	232,078	2,657,937	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	827,370	0	827,370	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,851,295	1,463,350	13,387,945	0	0	200.00
201.00		Less Observation Beds	827,370	0	827,370	0	0	201.00
202.00		Total (line 200 minus line 201)	14,023,925	1,463,350	12,560,575	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151334

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

Worksheet C Part II Date/Time Prepared: 5/31/2013 9:48 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	Tefra
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,479,460	4,162,232	0.595704		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	113,092	446,526	0.253271		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,368,444	15,039,845	0.157478		54.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	1,896,187	10,747,819	0.176425		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	109,980	83,628	1.315110		63.00
65.00	06500 RESPIRATORY THERAPY	725,937	2,135,826	0.339886		65.00
66.00	06600 PHYSICAL THERAPY	865,415	2,282,766	0.379108		66.00
69.00	06900 ELECTROCARDIOLOGY	290,444	1,291,467	0.224895		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	626,325	2,351,775	0.266320		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	152,390	199,818	0.762644		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,211,555	4,602,441	0.263242		73.00
76.00	03020 CARDIAC REHAB	216,767	144,714	1.497899		76.00
76.01	03021 SLEEP LAB	77,914	983,682	0.079206		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
91.00	09100 EMERGENCY	2,890,015	6,517,805	0.443403		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	827,370	578,327	1.430627		92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0	0	0.000000		99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000		111.00
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	14,851,295	51,568,671			200.00
201.00	Less Observation Beds	827,370	0			201.00
202.00	Total (line 200 minus line 201)	14,023,925	51,568,671			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/31/2013 9:48 am
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Cost Center Description		Title XVIII			Hospital		Capital Costs (column 3 x column 4)	
		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	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	552,396	4,162,232	0.132716	241,179	32,008	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,305	446,526	0.045473	1,195	54	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	221,050	15,039,845	0.014698	745,680	10,960	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	103,754	10,747,819	0.009653	1,498,897	14,469	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,953	83,628	0.023353	27,094	633	63.00
65.00	06500	RESPIRATORY THERAPY	93,173	2,135,826	0.043624	607,570	26,505	65.00
66.00	06600	PHYSICAL THERAPY	96,291	2,282,766	0.042182	48,420	2,042	66.00
69.00	06900	ELECTROCARDIOLOGY	7,661	1,291,467	0.005932	349,703	2,074	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,510	2,351,775	0.022753	544,700	12,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,769	199,818	0.013858	41,214	571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,101	4,602,441	0.007844	1,225,591	9,614	73.00
76.00	03020	CARDIAC REHAB	21,823	144,714	0.150801	179	27	76.00
76.01	03021	SLEEP LAB	20,486	983,682	0.020826	2,022	42	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	232,078	6,517,805	0.035607	337,784	12,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	578,327	0.000000	57,653	0	92.00
200.00		Total (lines 50-199)	1,463,350	51,568,671		5,728,881	123,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 9:48 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151334

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 9:48 am

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	4,162,232	0.000000	0.000000	241,179	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	446,526	0.000000	0.000000	1,195	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,039,845	0.000000	0.000000	745,680	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	10,747,819	0.000000	0.000000	1,498,897	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	83,628	0.000000	0.000000	27,094	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,135,826	0.000000	0.000000	607,570	65.00
66.00	06600	PHYSICAL THERAPY	0	2,282,766	0.000000	0.000000	48,420	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,291,467	0.000000	0.000000	349,703	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,351,775	0.000000	0.000000	544,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	199,818	0.000000	0.000000	41,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,602,441	0.000000	0.000000	1,225,591	73.00
76.00	03020	CARDIAC REHAB	0	144,714	0.000000	0.000000	179	76.00
76.01	03021	SLEEP LAB	0	983,682	0.000000	0.000000	2,022	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	6,517,805	0.000000	0.000000	337,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	578,327	0.000000	0.000000	57,653	92.00
200.00		Total (lines 50-199)	0	51,568,671			5,728,881	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 9:48 am

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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital Cost					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020 CARDIAC REHAB	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 9:48 am
	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	0.595704	0	782,630	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.253271	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.157478	0	3,785,455	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.176425	0	2,424,051	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1.315110	0	18,251	0	0
65.00 06500 RESPIRATORY THERAPY	0.339886	0	411,670	0	0
66.00 06600 PHYSICAL THERAPY	0.379108	0	598,576	0	0
69.00 06900 ELECTROCARDIOLOGY	0.224895	0	268,121	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266320	0	413,901	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.762644	0	7,638	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.263242	0	775,815	0	0
76.00 03020 CARDIAC REHAB	1.497899	0	357	0	0
76.01 03021 SLEEP LAB	0.079206	0	308,112	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.443403	0	1,157,801	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.430627	0	117,989	0	0
200.00 Subtotal (see instructions)		0	11,070,367	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	11,070,367	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 9:48 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	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	466,216	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	596,126	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	427,663	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	24,002	0		63.00
65.00 06500 RESPIRATORY THERAPY	139,921	0		65.00
66.00 06600 PHYSICAL THERAPY	226,925	0		66.00
69.00 06900 ELECTROCARDIOLOGY	60,299	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	110,230	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	5,825	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	204,227	0		73.00
76.00 03020 CARDIAC REHAB	535	0		76.00
76.01 03021 SLEEP LAB	24,404	0		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	513,372	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	168,798	0		92.00
200.00 Subtotal (see instructions)	2,968,543	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,968,543	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151334

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

Worksheet D
Part I
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		Title XIX			Hospital	Tefra		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	511,237	0	511,237	4,087	125.09	30.00	
31.00	INTENSIVE CARE UNIT	34,119		34,119	322	105.96	31.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	10,748		10,748	349	30.80	43.00	
200.00	Total (lines 30-199)	556,104		556,104	4,758		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	566	70,801					30.00
31.00	INTENSIVE CARE UNIT	51	5,404					31.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	290	8,932					43.00
200.00	Total (lines 30-199)	907	85,137					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151334

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

Worksheet D
Part II
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		Title XIX			Hospital	Tefra		
		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	552,396	4,162,232	0.132716	156,059	20,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,305	446,526	0.045473	34,687	1,577	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	221,050	15,039,845	0.014698	137,252	2,017	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	103,754	10,747,819	0.009653	221,957	2,143	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,953	83,628	0.023353	4,382	102	63.00
65.00	06500	RESPIRATORY THERAPY	93,173	2,135,826	0.043624	55,409	2,417	65.00
66.00	06600	PHYSICAL THERAPY	96,291	2,282,766	0.042182	11,108	469	66.00
69.00	06900	ELECTROCARDIOLOGY	7,661	1,291,467	0.005932	41,873	248	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,510	2,351,775	0.022753	174,191	3,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,769	199,818	0.013858	19,066	264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,101	4,602,441	0.007844	138,866	1,089	73.00
76.00	03020	CARDIAC REHAB	21,823	144,714	0.150801	0	0	76.00
76.01	03021	SLEEP LAB	20,486	983,682	0.020826	674	14	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	232,078	6,517,805	0.035607	56,421	2,009	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	104,324	578,327	0.180389	8,465	1,527	92.00
200.00		Total (lines 50-199)	1,567,674	51,568,671		1,060,410	38,551	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/31/2013 9:48 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Tefra Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,087	0.00	566	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	322	0.00	51	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	349	0.00	290	0	0	43.00
200.00		Total (lines 30-199)	4,758		907	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		Title XIX				Hospital	Tefra
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 9:48 am

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)	Tefra		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,162,232	0.000000	0.000000	156,059	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	446,526	0.000000	0.000000	34,687	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,039,845	0.000000	0.000000	137,252	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	10,747,819	0.000000	0.000000	221,957	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	83,628	0.000000	0.000000	4,382	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,135,826	0.000000	0.000000	55,409	65.00
66.00	06600	PHYSICAL THERAPY	0	2,282,766	0.000000	0.000000	11,108	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,291,467	0.000000	0.000000	41,873	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,351,775	0.000000	0.000000	174,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	199,818	0.000000	0.000000	19,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,602,441	0.000000	0.000000	138,866	73.00
76.00	03020	CARDIAC REHAB	0	144,714	0.000000	0.000000	0	76.00
76.01	03021	SLEEP LAB	0	983,682	0.000000	0.000000	674	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	6,517,805	0.000000	0.000000	56,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	578,327	0.000000	0.000000	8,465	92.00
200.00		Total (lines 50-199)	0	51,568,671			1,060,410	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XIX Hospital Tefra					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020 CARDIAC REHAB	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151334

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

Worksheet D
Part V
Date/Time Prepared:
5/31/2013 9:48 am

		Title XIX		Hospital		Tefra		
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	0.595704	0	311,259	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.253271	0	30,951	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157478	0	1,406,964	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.176425	0	903,167	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1.315110	0	3,972	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.339886	0	100,364	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379108	0	59,609	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.224895	0	112,591	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266320	0	279,446	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.762644	0	13,291	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263242	0	127,639	0	0	73.00
76.00	03020	CARDIAC REHAB	1.497899	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0.079206	0	124,239	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.443403	0	639,280	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.430627	0	52,615	0	0	92.00
200.00		Subtotal (see instructions)		0	4,165,387	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	4,165,387	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 9:48 am
		Title XIX	Hospital	Tefra

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	185,418	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,839	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	221,566	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	159,341	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5,224	0	63.00
65.00	06500 RESPIRATORY THERAPY	34,112	0	65.00
66.00	06600 PHYSICAL THERAPY	22,598	0	66.00
69.00	06900 ELECTROCARDIOLOGY	25,321	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	74,422	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10,136	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33,600	0	73.00
76.00	03020 CARDIAC REHAB	0	0	76.00
76.01	03021 SLEEP LAB	9,840	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100 EMERGENCY	283,459	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	75,272	0	92.00
200.00	Subtotal (see instructions)	1,148,148	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,148,148	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/31/2013 9:48 am
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)		4,087	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,087	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,253	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,806	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,054,515	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,054,515	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,476,163	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,476,163	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.746658	31.00
32.00	Average private room per diem charge (line 29 ÷ line 4)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		453.79	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,054,515	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)		992.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,791,642	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)		1,791,642	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 9:48 am	
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)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
Cost							
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	575,868	322	1,788.41	167	298,664	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,596,790	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,687,096	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)					834	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					992.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					827,370	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 9:48 am	
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: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/31/2013 9:48 am
Cost Center Description		Tefra		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,087	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,087	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,253	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		566	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)		349	15.00
16.00	Nursery days (title V or XIX only)		290	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,054,515	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,054,515	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,476,163	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,476,163	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.746658	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)		453.79	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,054,515	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)		992.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		561,500	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)		561,500	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Date/Time Prepared: 5/31/2013 9:48 am		Title XIX		Hospital		Tefra	
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)		
42.00 NURSERY (title V & XIX only)	233,249	349	668.34	290	193,819		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	575,868	322	1,788.41	51	91,209		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)					335,414		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,181,942		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)					85,137		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					38,551		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					123,688		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,058,254		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					200		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)					-1,058,254		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)					123,688		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)					834		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					992.05		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					827,370		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 9:48 am	
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	511,237	4,054,515	0.126091	827,370	104,324	90.00
91.00	Nursing School cost	0	4,054,515	0.000000	827,370	0	91.00
92.00	Allied health cost	0	4,054,515	0.000000	827,370	0	92.00
93.00	All other Medical Education	0	4,054,515	0.000000	827,370	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/31/2013 9:48 am	
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		778,201		30.00
31.00	03100 INTENSIVE CARE UNIT		156,462		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.595704	241,179	143,671	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.253271	1,195	303	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.157478	745,680	117,428	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.176425	1,498,897	264,443	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.315110	27,094	35,632	63.00
65.00	06500 RESPIRATORY THERAPY	0.339886	607,570	206,505	65.00
66.00	06600 PHYSICAL THERAPY	0.379108	48,420	18,356	66.00
69.00	06900 ELECTROCARDIOLOGY	0.224895	349,703	78,646	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266320	544,700	145,065	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.762644	41,214	31,432	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263242	1,225,591	322,627	73.00
76.00	03020 CARDIAC REHAB	1.497899	179	268	76.00
76.01	03021 SLEEP LAB	0.079206	2,022	160	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.443403	337,784	149,774	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.430627	57,653	82,480	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,728,881	1,596,790	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)		5,728,881		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/31/2013 9:48 am	
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		124,188		30.00
31.00	03100 INTENSIVE CARE UNIT		29,981		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		46,649		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.595704	156,059	92,965	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.253271	34,687	8,785	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.157478	137,252	21,614	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.176425	221,957	39,159	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1.315110	4,382	5,763	63.00
65.00	06500 RESPIRATORY THERAPY	0.339886	55,409	18,833	65.00
66.00	06600 PHYSICAL THERAPY	0.379108	11,108	4,211	66.00
69.00	06900 ELECTROCARDIOLOGY	0.224895	41,873	9,417	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.266320	174,191	46,391	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.762644	19,066	14,541	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263242	138,866	36,555	73.00
76.00	03020 CARDIAC REHAB	1.497899	0	0	76.00
76.01	03021 SLEEP LAB	0.079206	674	53	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.443403	56,421	25,017	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.430627	8,465	12,110	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,060,410	335,414	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)		1,060,410		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/31/2013 9:48 am
		Title VIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,968,543 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)			2,968,543 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)			2,998,228 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)			33,935 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,714,757 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,249,536 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,249,536 30.00
31.00	Primary payer payments			332 31.00
32.00	Subtotal (line 30 minus line 31)			1,249,204 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)			336,996 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			336,996 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			97,295 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,586,200 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,586,200 40.00
41.00	Interim payments			1,720,537 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)			-134,337 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: 151334

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2013 9:48 am

		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		2,951,622		1,720,537	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	08/24/2012	319,000		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)		319,000		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,270,622		1,720,537	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		55,808		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		134,337	6.02	
7.00	Total Medicare program liability (see instructions)		3,326,430		1,586,200	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/31/2013 9:48 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			3,687,096 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)			3,687,096 4.00
5.00	Primary payer payments			4,721 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,719,246 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)			3,719,246 19.00
20.00	Deductibles (exclude professional component)			419,532 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,299,714 22.00
23.00	Coinsurance			3,468 23.00
24.00	Subtotal (line 22 minus line 23)			3,296,246 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			30,184 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			30,184 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-13,781 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,326,430 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)			3,326,430 30.00
31.00	Interim payments			3,270,622 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)			55,808 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151334

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

Worksheet G

Date/Time Prepared:
5/31/2013 9:48 am

		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	2,287,112	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	683,738	0	0	0	3.00
4.00	Accounts receivable	26,600,095	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,610,523	0	0	0	6.00
7.00	Inventory	421,444	0	0	0	7.00
8.00	Prepaid expenses	111,164	0	0	0	8.00
9.00	Other current assets	-9,541	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)	7,483,489	0	0	0	11.00
FIXED ASSETS						
12.00	Land	241,233	0	0	0	12.00
13.00	Land improvements	520,508	0	0	0	13.00
14.00	Accumulated depreciation	-478,013	0	0	0	14.00
15.00	Buildings	22,876,858	0	0	0	15.00
16.00	Accumulated depreciation	-8,649,478	0	0	0	16.00
17.00	Leasehold improvements	-10,000	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,445,689	0	0	0	19.00
20.00	Accumulated depreciation	-2,027,255	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	14,874,599	0	0	0	23.00
24.00	Accumulated depreciation	-10,356,622	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)	19,437,519	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)	26,921,008	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,861,656	0	0	0	37.00
38.00	Salaries, wages, and fees payable	660,717	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,585,375	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,107,748	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,107,748	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,813,260				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)	21,813,260	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,921,008	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151334

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

Worksheet G-1

Date/Time Prepared:
5/31/2013 9:48 am

		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		24,129,115		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,315,855			2.00
3.00	Total (sum of line 1 and line 2)		21,813,260		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)		21,813,260		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)		21,813,260		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: 151334

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2013 9:48 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,970,465		1,970,465	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	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)	1,970,465		1,970,465	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	666,314		666,314	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)	666,314		666,314	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,636,779		2,636,779	17.00
18.00	Ancillary services	9,289,628	37,941,842	47,231,470	18.00
19.00	Outpatient services	619,231	6,395,187	7,014,418	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	241,854	1,863,138	2,104,992	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,787,492	46,200,167	58,987,659	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,847,477		29.00
30.00	ADD (SPECIFY)	7,059,401			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)		7,059,401		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)		29,906,878		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151334

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

Worksheet G-3

Date/Time Prepared:
5/31/2013 9:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,987,659	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,088,444	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,899,215	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,906,878	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,007,663	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	60,183	6.00
7.00	Income from investments	2,689	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	7,994	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	84,331	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	1,930	17.00
18.00	Revenue from sale of medical records and abstracts	12,571	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	496,165	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	25,945	24.00
25.00	Total other income (sum of lines 6-24)	691,808	25.00
26.00	Total (line 5 plus line 25)	-2,315,855	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,315,855	29.00