

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: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/28/2013 6:55 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/28/2013	Time: 6:55 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WOODLAWN HOSPITAL (151313) 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	223,870	-963,701	11,919	-93,316	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	10,644	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	234,514	-963,701	11,919	-93,316	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: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 6:54 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1400 EAST 9TH STREET			PO Box:							1.00	
2.00	City: ROCHESTER			State: IN		Zip Code: 46975-		County: FULTON			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	0	0	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF		WOODLAWN HOSPITAL SWINGBED	152313	99915		10/23/2001	N	0	N	7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital-Based SNF										9.00	
10.00	Hospital-Based NF										10.00	
11.00	Hospital-Based OLTC										11.00	
12.00	Hospital-Based HHA										12.00	
13.00	Separately Certified ASC										13.00	
14.00	Hospital-Based Hospice										14.00	
15.00	Hospital-Based Health Clinic - RHC										15.00	
16.00	Hospital-Based Health Clinic - FQHC										16.00	
17.00	Hospital-Based (CMHC) I										17.00	
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)						8		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.						3		N	23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0		24.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0		25.00			
							Urban/Rural	Date of Geogr				
							1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00		

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	231,142	0		118.01
				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	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
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.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							223,972	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: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/28/2013 6:54 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Type	Date
			1.00	2.00	3.00
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	Legal Oper.	
			1.00	2.00	
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)	Y	03/22/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/28/2013 6:54 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 2.00	3.00 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.			Y	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.			N	35.00
			Y/N 1.00	Date 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.	SALLY		CLEVELAND	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7920		SCLEVELAND@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/22/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 151313

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

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	87,336.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	87,336.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	9,816.00	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	97,152.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		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)	1,645	210	4,017			1.00
2.00 HMO	227	472				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	93	0	96			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	40			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,738	210	4,153			7.00
8.00 INTENSIVE CARE UNIT	191	0	409			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	1,929	210	4,562	0.00	0.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	0.00	27.00
28.00	Observation Bed Days		0	630			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	465	62	1,193	1.00
2.00	HMO			53			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	465	62	1,193	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/28/2013 6:54 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.331060	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,066,902	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		9,651,751	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,195,309	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,128,407	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,128,407	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,045,881	0	3,045,881	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,008,369	0	1,008,369	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,008,369	0	1,008,369	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,698,961	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		509,372	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		4,189,589	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,387,005	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,395,374	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,523,781	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,115,860	2,115,860	-17,844	2,098,016	1.00
1.01	00105	ROCHESTER BUILDING		0	0	0	0	1.01
1.02	00102	AKRON BUILDING		31,189	31,189	19,434	50,623	1.02
1.03	00103	ARGOS BUILDING		54,682	54,682	37,420	92,102	1.03
1.04	00101	CLAYS BUILDING		0	0	17,844	17,844	1.04
4.00	00400	EMPLOYEE BENEFITS	169,429	2,513,737	2,683,166	0	2,683,166	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,072,775	3,647,376	5,720,151	169,892	5,890,043	5.00
7.00	00700	OPERATION OF PLANT	263,802	1,009,169	1,272,971	0	1,272,971	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,934	98,092	123,026	0	123,026	8.00
9.00	00900	HOUSEKEEPING	297,274	145,195	442,469	0	442,469	9.00
10.00	01000	DIETARY	337,631	305,320	642,951	-412,022	230,929	10.00
11.00	01100	CAFETERIA	0	0	0	412,022	412,022	11.00
13.00	01300	NURSING ADMINISTRATION	148,669	37,121	185,790	0	185,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,049	49,517	78,566	0	78,566	14.00
15.00	01500	PHARMACY	267,719	2,841,537	3,109,256	0	3,109,256	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	449,527	171,093	620,620	0	620,620	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,352,190	918,555	3,270,745	0	3,270,745	30.00
31.00	03100	INTENSIVE CARE UNIT	377,365	126,480	503,845	0	503,845	31.00
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	804,317	1,679,472	2,483,789	0	2,483,789	50.00
51.00	05100	RECOVERY ROOM	302,980	106,477	409,457	0	409,457	51.00
53.00	05300	ANESTHESIOLOGY	0	678,797	678,797	0	678,797	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,266,329	1,319,626	2,585,955	0	2,585,955	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	651,077	1,329,271	1,980,348	0	1,980,348	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,009,280	314,476	1,323,756	0	1,323,756	65.00
66.00	06600	PHYSICAL THERAPY	931,318	209,622	1,140,940	0	1,140,940	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,054,351	1,054,351	0	1,054,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	807,063	1,785,234	2,592,297	0	2,592,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,562,728	22,542,249	35,104,977	226,746	35,331,723	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,239,147	1,877,883	8,117,030	-120,103	7,996,927	192.00
193.00	19300	NONPAID WORKERS	861	4,551	5,412	0	5,412	193.00
194.00	07950	ADVERTISING	84,287	321,809	406,096	-106,643	299,453	194.00
200.00		TOTAL (SUM OF LINES 118-199)	18,887,023	24,746,492	43,633,515	0	43,633,515	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151313

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

Worksheet A
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-83,137	2,014,879	1.00
1.01	00105	ROCHESTER BUILDING	0	0	1.01
1.02	00102	AKRON BUILDING	0	50,623	1.02
1.03	00103	ARGOS BUILDING	0	92,102	1.03
1.04	00101	CLAYS BUILDING	0	17,844	1.04
4.00	00400	EMPLOYEE BENEFITS	0	2,683,166	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,040,835	3,849,208	5.00
7.00	00700	OPERATION OF PLANT	0	1,272,971	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,026	8.00
9.00	00900	HOUSEKEEPING	0	442,469	9.00
10.00	01000	DIETARY	-34,602	196,327	10.00
11.00	01100	CAFETERIA	-127,529	284,493	11.00
13.00	01300	NURSING ADMINISTRATION	0	185,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-15,943	62,623	14.00
15.00	01500	PHARMACY	-511,502	2,597,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	620,620	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,270,745	30.00
31.00	03100	INTENSIVE CARE UNIT	0	503,845	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-59,021	2,424,768	50.00
51.00	05100	RECOVERY ROOM	0	409,457	51.00
53.00	05300	ANESTHESIOLOGY	-621,049	57,748	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-96,556	2,489,399	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,980,348	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-17,300	1,306,456	65.00
66.00	06600	PHYSICAL THERAPY	-102,562	1,038,378	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,054,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
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	-984,796	1,607,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,694,832	30,636,891	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,996,927	192.00
193.00	19300	NONPAID WORKERS	0	5,412	193.00
194.00	07950	ADVERTISING	0	299,453	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,694,832	38,938,683	200.00

RECLASSIFICATIONS

Provider CCN: 151313

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

Worksheet A-6

Date/Time Prepared:
5/28/2013 6:54 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	216,364	195,658	1.00
	TOTALS		216,364	195,658	
B - PHYSICIANS CLINIC					
1.00		0.00	0	0	1.00
2.00		0.00	0	0	2.00
3.00	AKRON BUILDING	1.02	0	19,434	3.00
4.00	ARGOS BUILDING	1.03	0	37,420	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	63,249	5.00
	TOTALS		0	120,103	
C - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	22,134	84,509	1.00
	TOTALS		22,134	84,509	
D - DEPRECIATION RECLASS					
1.00	CLAYS BUILDING	1.04	0	17,844	1.00
	TOTALS		0	17,844	
500.00	Grand Total: Increases		238,498	418,114	500.00

RECLASSIFICATIONS

Provider CCN: 151313

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

Worksheet A-6

Date/Time Prepared:
5/28/2013 6:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	216,364	195,658	0		1.00
	TOTALS		216,364	195,658			
B - PHYSICIANS CLINIC							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	120,103	10		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	120,103			
C - ADVERTISING							
1.00	ADVERTISING	194.00	22,134	84,509	0		1.00
	TOTALS		22,134	84,509			
D - DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	17,844	9		1.00
	TOTALS		0	17,844			
500.00	Grand Total: Decreases		238,498	418,114			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	345,223	250,993	0	250,993	0	1.00
2.00	Land Improvements	377,153	95,438	0	95,438	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	23,085,793	1,763,917	0	1,763,917	72,049	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,589,150	1,323,605	0	1,323,605	868,915	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,397,319	3,433,953	0	3,433,953	940,964	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,397,319	3,433,953	0	3,433,953	940,964	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	596,216	0				1.00
2.00	Land Improvements	472,591	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	24,777,661	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,043,840	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	33,890,308	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	33,890,308	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,182,336	0	567,077	344,250	22,197	1.00
1.01	ROCHESTER BUILDING	0	0	0	0	0	1.01
1.02	AKRON BUILDING	31,189	0	0	0	0	1.02
1.03	ARGOS BUILDING	54,682	0	0	0	0	1.03
1.04	CLAYS BUILDING	0	0	0	0	0	1.04
3.00	Total (sum of lines 1-2)	1,268,207	0	567,077	344,250	22,197	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	2,115,860				1.00
1.01	ROCHESTER BUILDING	0	0				1.01
1.02	AKRON BUILDING	0	31,189				1.02
1.03	ARGOS BUILDING	0	54,682				1.03
1.04	CLAYS BUILDING	0	0				1.04
3.00	Total (sum of lines 1-2)	0	2,201,731				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	ROCHESTER BUILDING	0	0	0	0.000000	0	1.01
1.02	AKRON BUILDING	0	0	0	0.000000	0	1.02
1.03	ARGOS BUILDING	0	0	0	0.000000	0	1.03
1.04	CLAYS BUILDING	0	0	0	0.000000	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. s. 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	1,104,938	0	1.00
1.01	ROCHESTER BUILDING	0	0	0	0	0	1.01
1.02	AKRON BUILDING	0	0	0	31,189	0	1.02
1.03	ARGOS BUILDING	0	0	0	54,682	0	1.03
1.04	CLAYS BUILDING	0	0	0	17,844	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,208,653	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 col. s. 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	543,494	344,250	22,197	0	2,014,879	1.00
1.01	ROCHESTER BUILDING	0	0	0	0	0	1.01
1.02	AKRON BUILDING	0	19,434	0	0	50,623	1.02
1.03	ARGOS BUILDING	0	37,420	0	0	92,102	1.03
1.04	CLAYS BUILDING	0	0	0	0	17,844	1.04
3.00	Total (sum of lines 1-2)	543,494	401,104	22,197	0	2,175,448	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151313

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

Worksheet A-8

Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
1.01 Investment income - ROCHESTER BUILDING (chapter 2)			0ROCHESTER BUILDING	1.01		0	1.01
1.02 Investment income - AKRON BUILDING (chapter 2)			0AKRON BUILDING	1.02		0	1.02
1.03 Investment income - ARGOS BUILDING (chapter 2)			0ARGOS BUILDING	1.03		0	1.03
1.04 Investment income - CLAYS BUILDING (chapter 2)			0CLAYS BUILDING	1.04		0	1.04
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,140,373				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests		0		0.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
26.01 Depreciation - ROCHESTER BUILDING			0ROCHESTER BUILDING	1.01		0	26.01
26.02 Depreciation - AKRON BUILDING			0AKRON BUILDING	1.02		0	26.02
26.03 Depreciation - ARGOS BUILDING			0ARGOS BUILDING	1.03		0	26.03
26.04 Depreciation - CLAYS BUILDING			0CLAYS BUILDING	1.04		0	26.04
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0*** Cost Center Deleted ***	2.00		0	27.00

Line #	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	
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	DELINQUENT A/R -INT INCME	B	-394	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 33.00
34.00	PATIENT ACCOUNTS - INT INCOME	B	-9,938	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 34.00
35.00	OTHER INCOME -INT INCME	B	-12,864	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 35.00
36.00	SAVINGS -INT INCME	B	-387	NEW CAP REL COSTS-BLDG & FIXT	1.00	11 36.00
37.00	EDUCATION OTHER REVENUE	B	-3,067	ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00	CLERICAL FEES -HIM	B	-21,926	ADMINISTRATIVE & GENERAL	5.00	0 38.00
39.00	MISC REV -OTH REV	B	-33,681	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.00	CHAPLAIN - OTHER REVENUE	B	-1,800	ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00	CHECKING -INT INCME	B	-3,210	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00	PATIENT SUPPLY/SUPPLEMENT CHAR	B	-1,336	DIETARY	10.00	0 42.00
43.00	HOME MEAL PROGRAM	B	-21,028	DIETARY	10.00	0 43.00
44.00	DIETARY SPEC EVENTS	B	-12,238	DIETARY	10.00	0 44.00
45.00	HOUSEKEEPING VENDING-OTH REV	B	-48	CAFETERIA	11.00	0 45.00
45.01	CAFETERIA SALES	B	-127,481	CAFETERIA	11.00	0 45.01
45.02	SUPPLY SALES	B	-15,943	CENTRAL SERVICES & SUPPLY	14.00	0 45.02
45.03	DRUG SALES	B	-511,502	PHARMACY	15.00	0 45.03
45.04	RESPIRATORY OTHER REV	B	-17,300	RESPIRATORY THERAPY	65.00	0 45.04
45.05	PT - OTHER REVENUE	B	-18,996	PHYSICAL THERAPY	66.00	0 45.05
45.06	OCC THER OTH REV	B	-68,566	PHYSICAL THERAPY	66.00	0 45.06
45.07	ATHLETIC TRAINING -OTH REV	B	-15,000	PHYSICAL THERAPY	66.00	0 45.07
45.08	PHYSICIAN RECRUITMENT	A	-71,985	ADMINISTRATIVE & GENERAL	5.00	0 45.08
45.09	PHYSICIAN RECRUITMENT	A	-40,781	ADMINISTRATIVE & GENERAL	5.00	0 45.09
45.10	IHA LOBBYING	A	-784	ADMINISTRATIVE & GENERAL	5.00	0 45.10
45.11	ANESTHESIA OFFSET	A	-621,049	ANESTHESIOLOGY	53.00	0 45.11
45.12	EHR DEPRECIATION OFFSET	A	-59,554	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 45.12
45.13	HAF	A	-1,863,601	ADMINISTRATIVE & GENERAL	5.00	0 45.13
45.14			0		0.00	0 45.14
45.15			0		0.00	0 45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,694,832			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2013 6:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	59,021	59,021	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	62,706	62,706	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	19,932	19,932	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	13,918	13,918	0	0	0	4.00
5.00	60.00	LABORATORY	24,996	0	24,996	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	450	0	450	0	0	6.00
7.00	91.00	EMERGENCY	1,471,794	981,196	490,598	0	0	7.00
8.00	91.00	EMERGENCY	3,600	3,600	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			1,656,417	1,140,373	516,044	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	59,021	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	62,706	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	19,932	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	13,918	4.00
5.00	60.00	LABORATORY	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	981,196	7.00
8.00	91.00	EMERGENCY	0	0	0	3,600	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	1,140,373	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	ROCHESTER BUILDING	AKRON BUILDING	ARGOS BUILDING		
		1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,014,879	2,014,879				1.00	
1.01 00105 ROCHESTER BUILDING	0	0	0			1.01	
1.02 00102 AKRON BUILDING	50,623	0	0	50,623		1.02	
1.03 00103 ARGOS BUILDING	92,102	0	0	0	92,102	1.03	
1.04 00101 CLAYS BUILDING	17,844	0	0	0	0	1.04	
4.00 00400 EMPLOYEE BENEFITS	2,683,166	7,437	0	0	0	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	3,849,208	494,824	0	5,785	7,368	5.00	
7.00 00700 OPERATION OF PLANT	1,272,971	176,248	0	3,471	8,400	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	123,026	6,354	0	0	0	8.00	
9.00 00900 HOUSEKEEPING	442,469	7,383	0	0	0	9.00	
10.00 01000 DIETARY	196,327	26,499	0	0	0	10.00	
11.00 01100 CAFETERIA	284,493	53,773	0	0	0	11.00	
13.00 01300 NURSING ADMINISTRATION	185,790	1,372	0	0	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	62,623	30,235	0	0	0	14.00	
15.00 01500 PHARMACY	2,597,754	13,394	0	0	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	620,620	26,372	0	0	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	3,270,745	234,786	0	0	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	503,845	33,286	0	0	0	31.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	2,424,768	254,822	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	409,457	7,545	0	0	0	51.00	
53.00 05300 ANESTHESIOLOGY	57,748	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,489,399	121,698	0	0	1,425	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	1,980,348	41,806	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	1,306,456	66,228	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	1,038,378	41,336	0	0	0	66.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,054,351	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
91.00 09100 EMERGENCY	1,607,501	109,676	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,636,891	1,755,074	0	9,256	17,193	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7,996,927	244,588	0	41,367	74,909	192.00	
193.00 19300 NONPAID WORKERS	5,412	0	0	0	0	193.00	
194.00 07950 ADVERTISING	299,453	15,217	0	0	0	194.00	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers		0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	38,938,683	2,014,879	0	50,623	92,102	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT		
	CLAYS BUILDING							
	1.04	4.00						
GENERAL SERVICE COST CENTERS								
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT							1.00	
1.01 00105 ROCHESTER BUILDING							1.01	
1.02 00102 AKRON BUILDING							1.02	
1.03 00103 ARGOS BUILDING							1.03	
1.04 00101 CLAYS BUILDING	17,844						1.04	
4.00 00400 EMPLOYEE BENEFITS	0	2,690,603					4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	0	301,137	4,658,322	4,658,322			5.00	
7.00 00700 OPERATION OF PLANT	11,896	37,921	1,510,907	205,316	1,716,223		7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	3,584	132,964	18,068	8,160		8.00	
9.00 00900 HOUSEKEEPING	0	42,732	492,584	66,937	9,481		9.00	
10.00 01000 DIETARY	0	17,432	240,258	32,648	34,031		10.00	
11.00 01100 CAFETERIA	0	31,102	369,368	50,193	69,058		11.00	
13.00 01300 NURSING ADMINISTRATION	0	21,371	208,533	28,337	1,762		13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	4,176	97,034	13,186	38,829		14.00	
15.00 01500 PHARMACY	0	38,484	2,649,632	360,056	17,201		15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	64,618	711,610	96,700	33,868		16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000 ADULTS & PEDIATRICS	0	338,120	3,843,651	522,310	301,522		30.00	
31.00 03100 INTENSIVE CARE UNIT	0	54,245	591,376	80,361	42,747		31.00	
41.00 04100 SUBPROVIDER - IIRF	0	0	0	0	0		41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0		42.00	
43.00 04300 NURSERY	0	0	0	0	0		43.00	
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	115,618	2,795,208	379,838	327,254		50.00	
51.00 05100 RECOVERY ROOM	0	43,552	460,554	62,584	9,690		51.00	
53.00 05300 ANESTHESIOLOGY	0	0	57,748	7,847	0		53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	182,031	2,794,553	379,749	156,290		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	93,590	2,115,744	287,506	53,688		60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0		60.01	
65.00 06500 RESPIRATORY THERAPY	0	145,081	1,517,765	206,248	85,053		65.00	
66.00 06600 PHYSICAL THERAPY	0	133,874	1,213,588	164,913	53,086		66.00	
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	1,054,351	143,275	0		72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00	
OUTPATIENT SERVICE COST CENTERS								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0		88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00	
91.00 09100 EMERGENCY	0	116,013	1,833,190	249,110	140,851		91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		92.00	
OTHER REIMBURSABLE COST CENTERS								
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0		96.00	
99.10 09910 CORF	0	0	0	0	0		99.10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0		101.00	
SPECIAL PURPOSE COST CENTERS								
113.00 11300 INTEREST EXPENSE	11,896	1,784,681	29,348,940	3,355,182	1,382,571		113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		11,896	1,784,681	29,348,940	3,355,182	1,382,571	118.00
NONREIMBURSABLE COST CENTERS								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00	
191.00 19100 RESEARCH	0	0	0	0	0		191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5,948	896,864	9,260,603	1,258,414	314,110		192.00	
193.00 19300 NONPAID WORKERS	0	124	5,536	752	0		193.00	
194.00 07950 ADVERTISING	0	8,934	323,604	43,974	19,542		194.00	
200.00	Cross Foot Adjustments		0	0	0		200.00	
201.00	Negative Cost Centers		0	0	0		201.00	
202.00	TOTAL (sum lines 118-201)		17,844	2,690,603	38,938,683	4,658,322	1,716,223	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00105						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	159,192	584,239				9.00
10.00	01000	15,237	1,620	310,276			10.00
11.00	01100	1,719	10,404	0	499,023		11.00
13.00	01300	0	3,411	0	4,258	246,301	13.00
14.00	01400	0	0	0	2,461	0	14.00
15.00	01500	0	5,458	0	15,062	0	15.00
16.00	01600	0	5,628	0	33,718	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	57,572	132,176	279,945	129,628	106,582	30.00
31.00	03100	5,099	21,575	30,331	12,010	16,284	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	33,854	104,138	0	62,686	39,028	50.00
51.00	05100	0	0	0	18,262	17,777	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,858	46,049	0	60,274	14,887	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	40,165	0	38,935	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	8,478	32,490	0	44,596	2,928	65.00
66.00	06600	3,379	21,063	0	37,926	0	66.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	21,996	60,716	0	38,985	48,815	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		159,192	484,893	310,276	498,801	246,301	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	97,385	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	1,961	0	222	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		159,192	584,239	310,276	499,023	246,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00105	ROCHESTER BUILDING					1.01
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	151,510				14.00
15.00	01500	PHARMACY	0	3,047,409			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	881,524		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,449	0	53,919	5,433,754	0 30.00
31.00	03100	INTENSIVE CARE UNIT	1,329	0	9,713	810,825	0 31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	85,528	0	115,259	3,942,793	0 50.00
51.00	05100	RECOVERY ROOM	3,298	0	16,866	589,031	0 51.00
53.00	05300	ANESTHESIOLOGY	1,825	0	15,628	83,048	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,603	0	182,961	3,656,224	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	3,558	0	132,234	2,671,830	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	2,633	0	64,723	1,964,914	0 65.00
66.00	06600	PHYSICAL THERAPY	770	0	24,148	1,518,873	0 66.00
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	26,632	1,224,258	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,047,409	158,379	3,205,788	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	5,207	0	81,062	2,479,932	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
99.10	09910	CORF	0	0	0	0	0 99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,200	3,047,409	881,524	27,581,270	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,310	0	0	10,961,822	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	6,288	0 193.00
194.00	07950	ADVERTISING	0	0	0	389,303	0 194.00
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	151,510	3,047,409	881,524	38,938,683	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00105 ROCHESTER BUILDING		1.01
1.02	00102 AKRON BUILDING		1.02
1.03	00103 ARGOS BUILDING		1.03
1.04	00101 CLAYS BUILDING		1.04
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	5,433,754	30.00
31.00	03100 INTENSIVE CARE UNIT	810,825	31.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	3,942,793	50.00
51.00	05100 RECOVERY ROOM	589,031	51.00
53.00	05300 ANESTHESIOLOGY	83,048	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,656,224	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	2,671,830	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	1,964,914	65.00
66.00	06600 PHYSICAL THERAPY	1,518,873	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,224,258	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,205,788	73.00
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	2,479,932	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	96.00
99.10	09910 CORF	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,581,270	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	10,961,822	192.00
193.00	19300 NONPAID WORKERS	6,288	193.00
194.00	07950 ADVERTISING	389,303	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	38,938,683	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	ROCHESTER BUILDING	AKRON BUILDING	ARGOS BUILDING		
		1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01 00105	ROCHESTER BUILDING					1.01	
1.02 00102	AKRON BUILDING					1.02	
1.03 00103	ARGOS BUILDING					1.03	
1.04 00101	CLAYS BUILDING					1.04	
4.00 00400	EMPLOYEE BENEFITS	0	7,437	0	0	4.00	
5.00 00500	ADMINISTRATIVE & GENERAL	0	494,824	0	5,785	7,368	5.00
7.00 00700	OPERATION OF PLANT	0	176,248	0	3,471	8,400	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,354	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	7,383	0	0	0	9.00
10.00 01000	DIETARY	0	26,499	0	0	0	10.00
11.00 01100	CAFETERIA	0	53,773	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,372	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	30,235	0	0	0	14.00
15.00 01500	PHARMACY	0	13,394	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	26,372	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	234,786	0	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	33,286	0	0	0	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	254,822	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	7,545	0	0	0	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	121,698	0	0	1,425	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	41,806	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	66,228	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	41,336	0	0	0	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
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	109,676	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,755,074	0	9,256	17,193	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	244,588	0	41,367	74,909	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ADVERTISING	0	15,217	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,014,879	0	50,623	92,102	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

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

Worksheet B
Part II
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Cost Center Description	CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT		
	CLAYS BUILDING						
	1.04	2A	4.00	5.00	7.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01 00105	ROCHESTER BUILDING					1.01	
1.02 00102	AKRON BUILDING					1.02	
1.03 00103	ARGOS BUILDING					1.03	
1.04 00101	CLAYS BUILDING					1.04	
4.00 00400	EMPLOYEE BENEFITS	0	7,437	7,437		4.00	
5.00 00500	ADMINISTRATIVE & GENERAL	0	507,977	832	508,809	5.00	
7.00 00700	OPERATION OF PLANT	11,896	200,015	105	22,426	222,546	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,354	10	1,974	1,058	8.00
9.00 00900	HOUSEKEEPING	0	7,383	118	7,311	1,229	9.00
10.00 01000	DIETARY	0	26,499	48	3,566	4,413	10.00
11.00 01100	CAFETERIA	0	53,773	86	5,483	8,955	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,372	59	3,095	228	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	30,235	12	1,440	5,035	14.00
15.00 01500	PHARMACY	0	13,394	106	39,328	2,230	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	26,372	178	10,562	4,392	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	234,786	934	57,051	39,099	30.00
31.00 03100	INTENSIVE CARE UNIT	0	33,286	150	8,778	5,543	31.00
41.00 04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	254,822	319	41,489	42,437	50.00
51.00 05100	RECOVERY ROOM	0	7,545	120	6,836	1,257	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	857	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	123,123	503	41,480	20,266	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	41,806	258	31,404	6,962	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	66,228	401	22,528	11,029	65.00
66.00 06600	PHYSICAL THERAPY	0	41,336	370	18,013	6,884	66.00
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	15,650	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	109,676	320	27,210	18,264	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE					113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,896	1,793,419	4,929	366,481	179,281	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,948	366,812	2,483	137,443	40,731	192.00
193.00 19300	NONPAID WORKERS	0	0	0	82	0	193.00
194.00 07950	ADVERTISING	0	15,217	25	4,803	2,534	194.00
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)	17,844	2,175,448	7,437	508,809	222,546	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00105	ROCHESTER BUILDING					1.01
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,396				8.00
9.00	00900	HOUSEKEEPING	899	16,940			9.00
10.00	01000	DIETARY	101	47	34,674		10.00
11.00	01100	CAFETERIA	0	302	0	68,599	11.00
13.00	01300	NURSING ADMINISTRATION	0	99	0	585	5,438
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	338	0
15.00	01500	PHARMACY	0	158	0	2,071	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	163	0	4,635	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,400	3,832	31,285	17,821	2,352
31.00	03100	INTENSIVE CARE UNIT	301	626	3,389	1,651	360
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	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,998	3,019	0	8,617	862
51.00	05100	RECOVERY ROOM	0	0	0	2,510	392
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	700	1,335	0	8,286	329
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	1,165	0	5,352	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	500	942	0	6,130	65
66.00	06600	PHYSICAL THERAPY	199	611	0	5,214	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	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	1,298	1,760	0	5,359	1,078
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,396	14,059	34,674	68,569	5,438
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,824	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ADVERTISING	0	57	0	30	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	9,396	16,940	34,674	68,599	5,438

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/28/2013 6:54 pm	
Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00105	ROCHESTER BUILDING					1.01
1.02	00102	AKRON BUILDING					1.02
1.03	00103	ARGOS BUILDING					1.03
1.04	00101	CLAYS BUILDING					1.04
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,060				14.00
15.00	01500	PHARMACY	0	57,287			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	46,302		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,577	0	2,833	394,970	0 30.00
31.00	03100	INTENSIVE CARE UNIT	325	0	510	54,919	0 31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,920	0	6,057	380,540	0 50.00
51.00	05100	RECOVERY ROOM	807	0	886	20,353	0 51.00
53.00	05300	ANESTHESIOLOGY	447	0	821	2,125	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,349	0	9,595	207,966	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	870	0	6,949	94,766	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	644	0	3,401	111,868	0 65.00
66.00	06600	PHYSICAL THERAPY	188	0	1,269	74,084	0 66.00
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	1,399	17,049	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	57,287	8,322	65,609	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	1,274	0	4,260	170,499	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
99.10	09910	CORF	0	0	0	0	0 99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,401	57,287	46,302	1,594,748	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,659	0	0	557,952	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	82	0 193.00
194.00	07950	ADVERTISING	0	0	0	22,666	0 194.00
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	37,060	57,287	46,302	2,175,448	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
1.01	00105	ROCHESTER BUILDING	1.01
1.02	00102	AKRON BUILDING	1.02
1.03	00103	ARGOS BUILDING	1.03
1.04	00101	CLAYS BUILDING	1.04
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	ADVERTISING	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1

Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		CAPITAL RELATED COSTS						
		NEW BLDG & FIXT	ROCHESTER BUI LDING	AKRON BUI LDING	ARGOS BUI LDING	CLAYS BUI LDING		
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
		1. 00	1. 01	1. 02	1. 03	1. 04		
GENERAL SERVICE COST CENTERS								
1. 00	00100	NEW CAP REL COSTS-BLDG & FIXT	111,623					1. 00
1. 01	00105	ROCHESTER BUI LDING	0	0				1. 01
1. 02	00102	AKRON BUI LDING	0	0	3,500			1. 02
1. 03	00103	ARGOS BUI LDING	0	0	0	7,500		1. 03
1. 04	00101	CLAYS BUI LDING	0	0	0	0	13,125	1. 04
4. 00	00400	EMPLOYEE BENEFITS	412	0	0	0	0	4. 00
5. 00	00500	ADMINISTRATIVE & GENERAL	27,413	0	400	600	0	5. 00
7. 00	00700	OPERATION OF PLANT	9,764	0	240	684	8,750	7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	352	0	0	0	0	8. 00
9. 00	00900	HOUSEKEEPING	409	0	0	0	0	9. 00
10. 00	01000	DIETARY	1,468	0	0	0	0	10. 00
11. 00	01100	CAFETERIA	2,979	0	0	0	0	11. 00
13. 00	01300	NURSING ADMINISTRATION	76	0	0	0	0	13. 00
14. 00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	0	0	0	14. 00
15. 00	01500	PHARMACY	742	0	0	0	0	15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	1,461	0	0	0	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00	03000	ADULTS & PEDIATRICS	13,007	0	0	0	0	30. 00
31. 00	03100	INTENSIVE CARE UNIT	1,844	0	0	0	0	31. 00
41. 00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41. 00
42. 00	04200	SUBPROVIDER	0	0	0	0	0	42. 00
43. 00	04300	NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS								
50. 00	05000	OPERATING ROOM	14,117	0	0	0	0	50. 00
51. 00	05100	RECOVERY ROOM	418	0	0	0	0	51. 00
53. 00	05300	ANESTHESIOLOGY	0	0	0	0	0	53. 00
54. 00	05400	RADIOLOGY-DIAGNOSTIC	6,742	0	0	116	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	2,316	0	0	0	0	60. 00
60. 01	06001	BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500	RESPIRATORY THERAPY	3,669	0	0	0	0	65. 00
66. 00	06600	PHYSICAL THERAPY	2,290	0	0	0	0	66. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS								
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	6,076	0	0	0	0	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS								
96. 00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
99. 10	09910	CORF	0	0	0	0	0	99. 10
101. 00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS								
113. 00	11300	INTEREST EXPENSE	0	0	0	0	0	113. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	97,230	0	640	1,400	8,750	118. 00
NONREIMBURSABLE COST CENTERS								
190. 00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00	19100	RESEARCH	0	0	0	0	0	191. 00
192. 00	19200	PHYSICIANS' PRIVATE OFFICES	13,550	0	2,860	6,100	4,375	192. 00
193. 00	19300	NONPAID WORKERS	0	0	0	0	0	193. 00
194. 00	07950	ADVERTISING	843	0	0	0	0	194. 00
200. 00		Cross Foot Adjustments						200. 00
201. 00		Negative Cost Centers						201. 00
202. 00		Cost to be allocated (per Wkst. B, Part I)	2,014,879	0	50,623	92,102	17,844	202. 00
203. 00		Unit cost multiplier (Wkst. B, Part I)	18.050751	0.000000	14.463714	12.280267	1.359543	203. 00
204. 00		Cost to be allocated (per Wkst. B, Part II)						204. 00
205. 00		Unit cost multiplier (Wkst. B, Part II)						205. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1

Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)		
		4.00	5A	5.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00105	ROCHESTER BUILDING					1.01	
1.02	00102	AKRON BUILDING					1.02	
1.03	00103	ARGOS BUILDING					1.03	
1.04	00101	CLAYS BUILDING					1.04	
4.00	00400	EMPLOYEE BENEFITS		18,717,594			4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	-4,658,322	2,094,909	34,280,361		5.00	
7.00	00700	OPERATION OF PLANT		263,802	1,510,907	74,034	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE		24,934	132,964	352	2,685	
9.00	00900	HOUSEKEEPING		297,274	492,584	409	257	
10.00	01000	DIETARY		121,267	240,258	1,468	29	
11.00	01100	CAFETERIA		216,364	369,368	2,979	0	
13.00	01300	NURSING ADMINISTRATION		148,669	208,533	76	0	
14.00	01400	CENTRAL SERVICES & SUPPLY		29,049	97,034	1,675	0	
15.00	01500	PHARMACY		267,719	2,649,632	742	0	
16.00	01600	MEDICAL RECORDS & LIBRARY		449,527	711,610	1,461	0	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		2,352,190	3,843,651	13,007	971	
31.00	03100	INTENSIVE CARE UNIT		377,365	591,376	1,844	86	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	
42.00	04200	SUBPROVIDER		0	0	0	0	
43.00	04300	NURSERY		0	0	0	0	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		804,317	2,795,208	14,117	571	
51.00	05100	RECOVERY ROOM		302,980	460,554	418	0	
53.00	05300	ANESTHESIOLOGY		0	57,748	0	0	
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,266,329	2,794,553	6,742	200	
57.00	05700	CT SCAN		0	0	0	0	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	
60.00	06000	LABORATORY		651,077	2,115,744	2,316	0	
60.01	06001	BLOOD LABORATORY		0	0	0	0	
65.00	06500	RESPIRATORY THERAPY		1,009,280	1,517,765	3,669	143	
66.00	06600	PHYSICAL THERAPY		931,318	1,213,588	2,290	57	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	1,054,351	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	
91.00	09100	EMERGENCY		807,063	1,833,190	6,076	371	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	
99.10	09910	CORF		0	0	0	0	
101.00	10100	HOME HEALTH AGENCY		0	0	0	0	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	
118.00		SUBTOTALS (SUM OF LINES 1-117)		12,415,433	-4,658,322	24,690,618	59,641	2,685
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0	
191.00	19100	RESEARCH		0	0	0	0	
192.00	19200	PHYSICIANS' PRIVATE OFFICES		6,239,147	9,260,603	13,550	0	
193.00	19300	NONPAID WORKERS		861	5,536	0	0	
194.00	07950	ADVERTISING		62,153	323,604	843	0	
200.00		Cross Foot Adjustments						
201.00		Negative Cost Centers						
202.00		Cost to be allocated (per Wkst. B, Part I)		2,690,603	4,658,322	1,716,223	159,192	
203.00		Unit cost multiplier (Wkst. B, Part I)		0.143747	0.135889	23.181552	59.289385	
204.00		Cost to be allocated (per Wkst. B, Part II)		7,437	508,809	222,546	9,396	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000397	0.014843	3.005997	3.499441	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1

Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00105						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00101						1.04
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	34,256					9.00
10.00	01000	95	4,184				10.00
11.00	01100	610	0	20,276			11.00
13.00	01300	200	0	173	150,148		13.00
14.00	01400	0	0	100	0	2,037,050	14.00
15.00	01500	320	0	612	0	0	15.00
16.00	01600	330	0	1,370	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,750	3,775	5,267	64,974	86,701	30.00
31.00	03100	1,265	409	488	9,927	17,866	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,106	0	2,547	23,792	1,149,914	50.00
51.00	05100	0	0	742	10,837	44,345	51.00
53.00	05300	0	0	0	0	24,543	53.00
54.00	05400	2,700	0	2,449	9,075	129,110	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,355	0	1,582	0	47,844	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,905	0	1,812	1,785	35,406	65.00
66.00	06600	1,235	0	1,541	0	10,354	66.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	3,560	0	1,584	29,758	70,005	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		28,431	4,184	20,267	150,148	1,616,088	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	5,710	0	0	0	420,962	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	115	0	9	0	0	194.00
200.00							200.00
201.00							201.00
202.00		584,239	310,276	499,023	246,301	151,510	202.00
203.00		17.055085	74.157744	24.611511	1.640388	0.074377	203.00
204.00		16,940	34,674	68,599	5,438	37,060	204.00
205.00		0.494512	8.287285	3.383261	0.036218	0.018193	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1

Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		15.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
1.01	00105			1.01
1.02	00102			1.02
1.03	00103			1.03
1.04	00101			1.04
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
14.00	01400			14.00
15.00	01500	100		15.00
16.00	01600	0	83,311,985	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	5,095,863	30.00
31.00	03100	0	917,942	31.00
41.00	04100	0	0	41.00
42.00	04200	0	0	42.00
43.00	04300	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	10,893,032	50.00
51.00	05100	0	1,594,023	51.00
53.00	05300	0	1,476,989	53.00
54.00	05400	0	17,291,305	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	12,497,330	60.00
60.01	06001	0	0	60.01
65.00	06500	0	6,116,935	65.00
66.00	06600	0	2,282,203	66.00
71.00	07100	0	0	71.00
72.00	07200	0	2,517,004	72.00
73.00	07300	100	14,968,236	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	0	0	88.00
89.00	08900	0	0	89.00
91.00	09100	0	7,661,123	91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600	0	0	96.00
99.10	09910	0	0	99.10
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
118.00		100	83,311,985	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
191.00	19100	0	0	191.00
192.00	19200	0	0	192.00
193.00	19300	0	0	193.00
194.00	07950	0	0	194.00
200.00				200.00
201.00				201.00
202.00		3,047,409	881,524	202.00
203.00		30,474.090000	0.010581	203.00
204.00		57,287	46,302	204.00
205.00		572.870000	0.000556	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	5,433,754		5,433,754	0	0	4,302,685	30.00
31.00	03100	INTENSIVE CARE UNIT	810,825		810,825	0	0	917,942	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,942,793		3,942,793	0	0	2,953,551	50.00
51.00	05100	RECOVERY ROOM	589,031		589,031	0	0	353,109	51.00
53.00	05300	ANESTHESIOLOGY	83,048		83,048	0	0	259,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,656,224		3,656,224	0	0	1,142,434	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	2,671,830		2,671,830	0	0	2,169,124	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,964,914	0	1,964,914	0	0	2,163,830	65.00
66.00	06600	PHYSICAL THERAPY	1,518,873	0	1,518,873	0	0	422,246	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,224,258		1,224,258	0	0	2,169,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,205,788		3,205,788	0	0	3,900,911	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00	09100	EMERGENCY	2,479,932		2,479,932	0	0	31,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	720,840		720,840	0	0	8,773	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	0	96.00
99.10	09910	CORF	0		0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	28,302,110	0	28,302,110	0	0	20,795,062	200.00
201.00		Less Observation Beds	720,840		720,840		0		201.00
202.00		Total (see instructions)	27,581,270	0	27,581,270	0	0	20,795,062	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
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		4,302,685					30.00
31.00	03100	INTENSIVE CARE UNIT		917,942					31.00
41.00	04100	SUBPROVIDER - I RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		0					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,939,481	10,893,032	0.361956	0.000000	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,240,914	1,594,023	0.369525	0.000000	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	1,217,988	1,476,989	0.056228	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,148,871	17,291,305	0.211449	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	10,328,206	12,497,330	0.213792	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	3,953,105	6,116,935	0.321225	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,859,957	2,282,203	0.665529	0.000000	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	347,302	2,517,004	0.486395	0.000000	0.000000		72.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C
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Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost
			Outpatient	Total (col. 6 + col. 7)				
7.00	8.00	9.00	10.00	11.00				
73.00	07300	DRUGS CHARGED TO PATIENTS	11,067,325	14,968,236	0.214173	0.000000	0.000000	73.00
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	7,629,369	7,661,123	0.323703	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	784,405	793,178	0.908800	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0.000000	96.00
99.10	09910	CORF	0	0				99.10
101.00	10100	HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	62,516,923	83,311,985				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,516,923	83,311,985				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

Period:
From 01/01/2012
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Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Dissallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	5,433,754		5,433,754	0	0	4,302,685	30.00
31.00	03100	INTENSIVE CARE UNIT	810,825		810,825	0	0	917,942	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,942,793		3,942,793	0	0	2,953,551	50.00
51.00	05100	RECOVERY ROOM	589,031		589,031	0	0	353,109	51.00
53.00	05300	ANESTHESIOLOGY	83,048		83,048	0	0	259,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,656,224		3,656,224	0	0	1,142,434	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	2,671,830		2,671,830	0	0	2,169,124	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,964,914	0	1,964,914	0	0	2,163,830	65.00
66.00	06600	PHYSICAL THERAPY	1,518,873	0	1,518,873	0	0	422,246	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,224,258		1,224,258	0	0	2,169,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,205,788		3,205,788	0	0	3,900,911	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00	09100	EMERGENCY	2,479,932		2,479,932	0	0	31,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	720,840		720,840	0	0	8,773	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	0	96.00
99.10	09910	CORF	0		0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	28,302,110	0	28,302,110	0	0	20,795,062	200.00
201.00		Less Observation Beds	720,840		720,840		0		201.00
202.00		Total (see instructions)	27,581,270	0	27,581,270	0	0	20,795,062	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		4,302,685					30.00
31.00	03100	INTENSIVE CARE UNIT		917,942					31.00
41.00	04100	SUBPROVIDER - I RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		0					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,939,481	10,893,032	0.361956	0.000000	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,240,914	1,594,023	0.369525	0.000000	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	1,217,988	1,476,989	0.056228	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,148,871	17,291,305	0.211449	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	10,328,206	12,497,330	0.213792	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	3,953,105	6,116,935	0.321225	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,859,957	2,282,203	0.665529	0.000000	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	347,302	2,517,004	0.486395	0.000000	0.000000		72.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C
Part I
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Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost
			Outpatient	Total (col. 6 + col. 7)				
7.00	8.00	9.00	10.00	11.00				
73.00	07300	DRUGS CHARGED TO PATIENTS	11,067,325	14,968,236	0.214173	0.000000	0.000000	73.00
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	7,629,369	7,661,123	0.323703	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	784,405	793,178	0.908800	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0.000000	96.00
99.10	09910	CORF	0	0				99.10
101.00	10100	HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	62,516,923	83,311,985				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,516,923	83,311,985				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/28/2013 6:54 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	380,540	10,893,032	0.034934	1,007,895	35,210	50.00
51.00	05100 RECOVERY ROOM	20,353	1,594,023	0.012768	104,714	1,337	51.00
53.00	05300 ANESTHESIOLOGY	2,125	1,476,989	0.001439	79,116	114	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	207,966	17,291,305	0.012027	564,549	6,790	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	94,766	12,497,330	0.007583	1,039,880	7,885	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	111,868	6,116,935	0.018288	1,137,029	20,794	65.00
66.00	06600 PHYSICAL THERAPY	74,084	2,282,203	0.032462	206,560	6,705	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	17,049	2,517,004	0.006774	706,034	4,783	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	65,609	14,968,236	0.004383	1,725,552	7,563	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	170,499	7,661,123	0.022255	1,076	24	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	793,178	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	1,144,859	78,091,358		6,572,405	91,205	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151313

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151313

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	10,893,032	0.000000	0.000000	1,007,895	50.00
51.00	05100 RECOVERY ROOM	0	1,594,023	0.000000	0.000000	104,714	51.00
53.00	05300 ANESTHESIOLOGY	0	1,476,989	0.000000	0.000000	79,116	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,291,305	0.000000	0.000000	564,549	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	12,497,330	0.000000	0.000000	1,039,880	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	6,116,935	0.000000	0.000000	1,137,029	65.00
66.00	06600 PHYSICAL THERAPY	0	2,282,203	0.000000	0.000000	206,560	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,517,004	0.000000	0.000000	706,034	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14,968,236	0.000000	0.000000	1,725,552	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	7,661,123	0.000000	0.000000	1,076	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	793,178	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	78,091,358			6,572,405	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/28/2013 6:54 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
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
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151313

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

Worksheet D
Part V
Date/Time Prepared:
5/28/2013 6:54 pm

		Title XVIII		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.361956	0	1,466,513	0	0	50.00
51.00	05100	RECOVERY ROOM	0.369525	0	246,696	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.056228	0	265,716	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211449	0	3,831,039	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	0.213792	0	2,987,863	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.321225	0	1,236,832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.665529	0	442,845	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.486395	0	20,438	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214173	0	5,048,783	402	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.323703	0	1,701,315	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.908800	0	217,298	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	17,465,338	402	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	17,465,338	402	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 6:54 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	530,813	0	50.00
51.00	05100 RECOVERY ROOM	91,160	0	51.00
53.00	05300 ANESTHESIOLOGY	14,941	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	810,069	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	638,781	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	397,301	0	65.00
66.00	06600 PHYSICAL THERAPY	294,726	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,941	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,081,313	86	73.00
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	550,721	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	197,480	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	4,617,246	86	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	4,617,246	86	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 6:54 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.361956	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.369525	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.056228	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211449	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.213792	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.321225	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.665529	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.486395	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214173	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.323703	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.908800	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 6:54 pm
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
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	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2013 6:54 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,783	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,647	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)		4,017	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		96	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		40	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)		1,645	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)		93	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		171.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,433,754	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)		6,844	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)		116,686	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,317,068	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,970,152	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,970,152	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.890608	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,486.22	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)		5,317,068	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,144.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,882,193	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)		1,882,193	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Title XVIII		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	810,825	409	1,982.46	191	378,650	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)					1,965,688	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,226,531	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)					106,410	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)					106,410	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)					630	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,144.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					720,840	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/28/2013 6:54 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/28/2013 6:54 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,783	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,647	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)		4,017	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		96	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		40	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)		210	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		171.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,433,754	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)		6,844	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)		116,686	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,317,068	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,970,152	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,970,152	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.890608	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,486.22	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)		5,317,068	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,144.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		240,280	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)		240,280	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Date/Time Prepared: 5/28/2013 6:54 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	810,825	409	1,982.46	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					206,485		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					446,765		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)						630	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,144.19	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						720,840	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/28/2013 6:54 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/28/2013 6:54 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,726,709		30.00
31.00	03100 INTENSIVE CARE UNIT		412,664		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	0.361956	1,007,895	364,814	50.00
51.00	05100 RECOVERY ROOM	0.369525	104,714	38,694	51.00
53.00	05300 ANESTHESIOLOGY	0.056228	79,116	4,449	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211449	564,549	119,373	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	0.213792	1,039,880	222,318	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.321225	1,137,029	365,242	65.00
66.00	06600 PHYSICAL THERAPY	0.665529	206,560	137,472	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.486395	706,034	343,411	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214173	1,725,552	369,567	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.323703	1,076	348	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.908800	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		6,572,405	1,965,688	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)		6,572,405		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2012	Worksheet D-3
		Component CCN: 15Z313	To 12/31/2012	Date/Time Prepared: 5/28/2013 6:54 pm
		Title XVIII	Swing Beds - SNF	Cost

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		29,650		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.361956	4,293	1,554	50.00
51.00	05100 RECOVERY ROOM	0.369525	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.056228	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211449	3,217	680	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	0.213792	10,037	2,146	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.321225	21,538	6,919	65.00
66.00	06600 PHYSICAL THERAPY	0.665529	37,844	25,186	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.486395	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214173	63,492	13,598	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.323703	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.908800	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		140,421	50,083	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)		140,421		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/28/2013 6:54 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		296,737		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.361956	183,567	66,443	50.00
51.00	05100 RECOVERY ROOM	0.369525	27,340	10,103	51.00
53.00	05300 ANESTHESIOLOGY	0.056228	17,528	986	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211449	38,398	8,119	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	0.213792	100,096	21,400	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.321225	82,038	26,353	65.00
66.00	06600 PHYSICAL THERAPY	0.665529	7,783	5,180	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.486395	43,949	21,377	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.214173	199,389	42,704	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.323703	9,119	2,952	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.908800	955	868	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		710,162	206,485	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)		710,162		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/28/2013 6:54 pm
		Title VIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,617,332 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,617,332 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,663,505 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)			27,282 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,884,428 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)			1,751,795 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)			1,751,795 30.00
31.00	Primary payer payments			2,377 31.00
32.00	Subtotal (line 30 minus line 31)			1,749,418 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)			501,635 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			501,635 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			261,138 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,251,053 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,251,053 40.00
41.00	Interim payments			3,214,754 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)			-963,701 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: 151313

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,586,097		2,969,410	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	01/01/2012	37,112	01/01/2012	245,344	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)		37,112		245,344	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)		3,623,209		3,214,754	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		223,870		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		963,701	6.02	
7.00	Total Medicare program liability (see instructions)		3,847,079		2,251,053	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151313
Component CCN: 15Z313

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2013 6:54 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		145,680		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		145,680		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		10,644		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		156,324		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151313

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2013 6:54 pm

		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,193	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,836	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			227	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			4,426	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			83,311,985	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			3,045,881	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			223,972	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			153,156	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			141,237	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			11,919	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151313
Component CCN: 15Z313

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

Worksheet E-2
Date/Time Prepared:
5/28/2013 6:54 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	107,474	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	50,584	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	93	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	158,058	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	158,058	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	158,058	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,734	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	156,324	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Reimbursable bad debts (see instructions)	0	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	156,324	0	19.00	
20.00	Interim payments	145,680	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	10,644	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/28/2013 6:54 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			4,226,531 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)			4,226,531 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,268,796 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)			4,268,796 19.00
20.00	Deductibles (exclude professional component)			427,720 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,841,076 22.00
23.00	Coinsurance			1,734 23.00
24.00	Subtotal (line 22 minus line 23)			3,839,342 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			7,737 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			7,737 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,847,079 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)			3,847,079 30.00
31.00	Interim payments			3,623,209 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)			223,870 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			435,193 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2013 6:54 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		446,765		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		446,765	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		446,765	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		296,737		8.00
9.00	Ancillary service charges		710,162	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,006,899	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,006,899	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		560,134	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		446,765	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		446,765	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		446,765	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		446,765	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		446,765	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		446,765	0	40.00
41.00	Interim payments		540,081	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-93,316	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151313

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

Worksheet G

Date/Time Prepared:
5/28/2013 6:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,551,385	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,157,287	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,049,729	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,454,881	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)	10,213,282	0	0	0	11.00
FIXED ASSETS						
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,945,445	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,541,661	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	2,430,151	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,430,151	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,185,094	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,680,271	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,535,776	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,069,180	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,285,227	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	11,346,234	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,346,234	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,631,461	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,553,633				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)	14,553,633	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,185,094	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151313

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

Worksheet G-1

Date/Time Prepared:
5/28/2013 6:54 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		12,662,161		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,891,472			2.00
3.00	Total (sum of line 1 and line 2)		14,553,633		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)		14,553,633		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)		14,553,633		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: 151313

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2013 6:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,051,103		5,051,103	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)	5,051,103		5,051,103	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	962,702		962,702	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)	962,702		962,702	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,013,805		6,013,805	17.00
18.00	Ancillary services	15,537,681	54,202,454	69,740,135	18.00
19.00	Outpatient services	44,549	9,651,210	9,695,759	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	PHYSICIANS OFFICES	0	11,339,536	11,339,536	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,596,035	75,193,200	96,789,235	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		43,633,515		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		43,633,515		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151313

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

Worksheet G-3

Date/Time Prepared:
5/28/2013 6:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	96,789,235	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,177,607	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,611,628	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,633,515	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,887	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,884,321	24.00
24.01	INVESTMENT INCOME	9,647	24.01
24.02	LOSS ON DISPOSITION OF ASSETS	-7,305	24.02
24.03	OTHER NONOPERATING INCOME (EXPENSE)	23,196	24.03
24.04	OTHER REVENUE ADJUSTMENT	3,500	24.04
25.00	Total other income (sum of lines 6-24)	1,913,359	25.00
26.00	Total (line 5 plus line 25)	1,891,472	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)	1,891,472	29.00