This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 5:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 PROCTOR HOSPITAL (140013) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-2,143	-2,589	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-11		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	-1	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-2,144	-2,599	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PROCTOR HOSPITAL	147049	37900		09/01/1997	N	P	P	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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	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.	1,103	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		Beginning:	Ending:	
		1.00	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	Y/N	
		1.00	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	XVIII	XIX	
		1.00	2.00	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	Y	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	IME Average	Direct GME Average	
		1.00	2.00	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	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 5:13 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		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)	N		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)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	746,681	0	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)	Y		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:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		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	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2013 5:13 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	05/02/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 5:13 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					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.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					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.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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.	DANIEL	LINHART			41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 5:13 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/02/2013			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00

			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HFS Supplemental Information | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part IX | Date/Time Prepared: 5/29/2013 5:13 pm

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2013 5:13 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	130	47,580	0.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		130	47,580	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		142	51,972	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,320		0	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
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		162				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	11,988	796	22,224			1.00
2.00	HMO	2,212	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	11,988	796	22,224			7.00
8.00	INTENSIVE CARE UNIT	1,402	92	2,533			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		215	1,273			13.00
14.00	Total (see instructions)	13,390	1,103	26,030	0.00	784.99	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,231	0	4,450	0.00	22.21	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,662	0	5,162	0.00	6.92	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)				0.00	814.12	27.00
28.00	Observation Bed Days		0	1,950			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			207			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	2,777	433	6,053	1.00
2.00	HMO			527			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	2,777	433	6,053	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2013 5:13 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,859,258	0	38,859,258	1,655,445.00	23.47	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,058,928	43,930	1,102,858	50,556.00	21.81	9.00
10.00	Excluded area salaries (see instructions)		2,345,563	203,064	2,548,627	126,550.00	20.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		2,501,016	0	2,501,016	60,051.00	41.65	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		98,062	0	98,062	1,040.00	94.29	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		11,305,883	0	11,305,883			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		1,168,281	0	1,168,281			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	98,122	0	98,122	2,047.00	47.93	26.00
27.00	Administrative & General	5.00	6,114,308	0	6,114,308	232,037.00	26.35	27.00
28.00	Administrative & General under contract (see inst.)		444,113	0	444,113	2,559.00	173.55	28.00
29.00	Maintenance & Repairs	6.00	810	0	810	1.00	810.00	29.00
30.00	Operation of Plant	7.00	1,076,341	0	1,076,341	51,411.00	20.94	30.00
31.00	Laundry & Linen Service	8.00	42,988	0	42,988	4,282.00	10.04	31.00
32.00	Housekeeping	9.00	947,972	0	947,972	81,301.00	11.66	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	755,978	-509,864	246,114	19,725.00	12.48	34.00
35.00	Dietary under contract (see instructions)		360,251	0	360,251	10,400.00	34.64	35.00
36.00	Cafeteria	11.00	0	262,870	262,870	21,068.00	12.48	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	692,213	0	692,213	27,661.00	25.02	38.00
39.00	Central Services and Supply	14.00	228,485	0	228,485	17,482.00	13.07	39.00
40.00	Pharmacy	15.00	1,120,370	0	1,120,370	33,020.00	33.93	40.00
41.00	Medical Records & Medical Records Library	16.00	800,947	0	800,947	47,573.00	16.84	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2013 5:13 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	145,360	0	145,360	7,510.00	19.36	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2013 5:13 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		39,663,622	0	39,663,622	1,668,404.00	23.77	1.00
2.00	Excluded area salaries (see instructions)		3,404,491	246,994	3,651,485	177,106.00	20.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)		36,259,131	-246,994	36,012,137	1,491,298.00	24.15	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,599,078	0	2,599,078	61,091.00	42.54	4.00
5.00	Subtotal wage-related costs (see inst.)		11,305,883	0	11,305,883	0.00	31.39	5.00
6.00	Total (sum of lines 3 thru 5)		50,164,092	-246,994	49,917,098	1,552,389.00	32.16	6.00
7.00	Total overhead cost (see instructions)		12,828,258	-246,994	12,581,264	558,077.00	22.54	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2013 5:13 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	950,874	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,083,552	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5,113,128	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,441	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	252,200	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	911,657	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,862,887	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	115,050	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	68,955	22.00
23.00	Tuition Reimbursement	81,420	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,474,164	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,534,093	12,474,164	1.00
2.00	Hospital	2,446,746	11,261,247	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	32,323	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	1,250	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	53,774	1,212,917	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140013 | Component CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-4 | Date/Time Prepared: 5/29/2013 5:13 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	246.00	1.00	187.00	449.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.04	0.00	1.04	5.00
6.00	Direct Nursing Service			10.23	0.00	10.23	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			37900			20.00
20.01				99914			20.01
20.02				99916			20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,065	28	128	24	1,245	21.00
22.00	Skilled Nursing Visit Charges	256,063	6,629	30,806	5,777	299,275	22.00
23.00	Physical Therapy Visits	1,160	2	40	44	1,246	23.00
24.00	Physical Therapy Visit Charges	347,440	584	11,960	13,184	373,168	24.00
25.00	Occupational Therapy Visits	133	0	1	15	149	25.00
26.00	Occupational Therapy Visit Charges	39,876	0	300	4,500	44,676	26.00
27.00	Speech Pathology Visits	19	0	1	0	20	27.00
28.00	Speech Pathology Visit Charges	5,692	0	300	0	5,992	28.00
29.00	Medical Social Service Visits	1	1	0	0	2	29.00
30.00	Medical Social Service Visit Charges	300	292	0	0	592	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,378	31	170	83	2,662	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	649,371	7,505	43,366	23,461	723,703	35.00
36.00	Total Number of Episodes (standard/non outlier)	218		58	6	282	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	9,353	0	508	50	9,911	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet S-7 Date/Time Prepared: 5/29/2013 5:13 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	11	0	11	4.00
5.00		RVX	12	0	12	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	45	0	45	8.00
9.00		RMX	19	0	19	9.00
10.00		RML	14	0	14	10.00
11.00		RLX	2	0	2	11.00
12.00		RUC	39	0	39	12.00
13.00		RUB	104	0	104	13.00
14.00		RUA	113	0	113	14.00
15.00		RVC	146	0	146	15.00
16.00		RVB	423	0	423	16.00
17.00		RVA	472	0	472	17.00
18.00		RHC	283	0	283	18.00
19.00		RHB	458	0	458	19.00
20.00		RHA	525	0	525	20.00
21.00		RMC	22	0	22	21.00
22.00		RMB	63	0	63	22.00
23.00		RMA	70	0	70	23.00
24.00		RLB	7	0	7	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	39	0	39	28.00
29.00		HE2	24	0	24	29.00
30.00		HE1	46	0	46	30.00
31.00		HD2	23	0	23	31.00
32.00		HD1	31	0	31	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	10	0	10	35.00
36.00		HB1	139	0	139	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	11	0	11	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	39	0	39	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	8	0	8	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	2	0	2	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	21	0	21	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	8	0	8	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-7 | Date/Time Prepared: 5/29/2013 5:13 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,231	0	3,231	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,052,404	38.82	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,711,147			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/29/2013 5:13 pm

		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)	0.258486	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,863,438	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	11,503,190	6.00
7.00	Medicaid cost (line 1 times line 6)	2,973,414	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)	1,109,976	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)	1,109,976	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,168,522	0	3,168,522	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	819,019	0	819,019	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)	819,019	0	819,019	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,296,032	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	317,670	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,978,362	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,028,351	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,847,370	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,957,346	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		3,533,557	3,533,557	-224,777	3,308,780	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,839,062	4,839,062	0	4,839,062	2.00
4.00	00400	EMPLOYEE BENEFITS	98,122	10,074,121	10,172,243	-22,888	10,149,355	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,114,308	7,843,646	13,957,954	-199,418	13,758,536	5.00
6.00	00600	MAINTENANCE & REPAIRS	810	1,218,754	1,219,564	84,612	1,304,176	6.00
7.00	00700	OPERATION OF PLANT	1,076,341	721,766	1,798,107	90,444	1,888,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,988	435,670	478,658	0	478,658	8.00
9.00	00900	HOUSEKEEPING	947,972	177,164	1,125,136	183,473	1,308,609	9.00
10.00	01000	DIETARY	755,978	1,148,585	1,904,563	-1,284,516	620,047	10.00
11.00	01100	CAFETERIA	0	0	0	662,257	662,257	11.00
13.00	01300	NURSING ADMINISTRATION	692,213	133,284	825,497	0	825,497	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	228,485	75,654	304,139	-102,870	201,269	14.00
15.00	01500	PHARMACY	1,120,370	472,300	1,592,670	-86,643	1,506,027	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	800,947	2,281,954	3,082,901	0	3,082,901	16.00
17.00	01700	SOCIAL SERVICE	145,360	22,694	168,054	0	168,054	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,822,654	1,629,219	8,451,873	-859,066	7,592,807	30.00
31.00	03100	INTENSIVE CARE UNIT	1,822,190	405,248	2,227,438	-193,266	2,034,172	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	342,707	342,707	43.00
44.00	04400	SKILLED NURSING FACILITY	1,058,928	115,686	1,174,614	46,895	1,221,509	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,612,215	14,192,648	18,804,863	-12,662,120	6,142,743	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	874,798	381,961	1,256,759	-123,980	1,132,779	52.00
53.00	05300	ANESTHESIOLOGY	48,797	370,343	419,140	-279,488	139,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,702,640	1,927,906	3,630,546	-127,404	3,503,142	54.00
60.00	06000	LABORATORY	1,612,500	2,858,140	4,470,640	-180,986	4,289,654	60.00
65.00	06500	RESPIRATORY THERAPY	1,128,183	299,488	1,427,671	-99,073	1,328,598	65.00
66.00	06600	PHYSICAL THERAPY	235,945	2,284,791	2,520,736	-445,475	2,075,261	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,037,624	5,497,020	6,534,644	-3,287,642	3,247,002	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,404,399	7,404,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11,213,720	11,213,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,658,058	2,658,058	3,541	2,661,599	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	182,750	131,071	313,821	-4,459	309,362	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,267,274	1,940,941	3,208,215	-366	3,207,849	90.00
91.00	09100	EMERGENCY	2,083,303	545,432	2,628,735	-359,196	2,269,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	415,808	295,883	711,691	0	711,691	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,929,503	68,512,046	105,441,549	-511,585	104,929,964	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	22,120	22,120	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	277,663	277,663	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	398,059	64,106	462,165	73,111	535,276	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	691,670	348,304	1,039,974	138,691	1,178,665	194.09
194.10	07960	ARC INGALLS	840,026	237,898	1,077,924	0	1,077,924	194.10
200.00		TOTAL (SUM OF LINES 118-199)	38,859,258	69,162,354	108,021,612	0	108,021,612	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/29/2013 5:13 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	-218,883	3,089,897		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-6,998	4,832,064		2.00
4.00	00400	EMPLOYEE BENEFITS	-1,853,647	8,295,708		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,529,569	12,228,967		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,304,176		6.00
7.00	00700	OPERATION OF PLANT	-79,444	1,809,107		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-4,554	474,104		8.00
9.00	00900	HOUSEKEEPING	0	1,308,609		9.00
10.00	01000	DIETARY	0	620,047		10.00
11.00	01100	CAFETERIA	0	662,257		11.00
13.00	01300	NURSING ADMINISTRATION	-450	825,047		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	201,269		14.00
15.00	01500	PHARMACY	0	1,506,027		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,818	3,081,083		16.00
17.00	01700	SOCIAL SERVICE	0	168,054		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-652,409	6,940,398		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,034,172		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	342,707		43.00
44.00	04400	SKILLED NURSING FACILITY	-1,000	1,220,509		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,142,743		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-189,717	943,062		52.00
53.00	05300	ANESTHESIOLOGY	0	139,652		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,078	3,492,064		54.00
60.00	06000	LABORATORY	-109,658	4,179,996		60.00
65.00	06500	RESPIRATORY THERAPY	-20,000	1,308,598		65.00
66.00	06600	PHYSICAL THERAPY	0	2,075,261		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,247,002		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,404,399		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,213,720		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,661,599		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-70,466	238,896		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-473,846	2,734,003		90.00
91.00	09100	EMERGENCY	-1,493,565	775,974		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-2,603	709,088		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,719,705	98,210,259		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	0		194.01
194.02	07952	MARKETING	0	0		194.02
194.03	07953	GUEST MEALS	0	22,120		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	277,663		194.04
194.05	07955	FOUNDATION	0	0		194.05
194.06	07956	DAYCARE CENTER	0	535,276		194.06
194.07	07957	UN-USED SQR FT - POB	0	0		194.07
194.08	07958	SENIOR SERVICES	0	0		194.08
194.09	07959	ARC BROMENN	0	1,178,665		194.09
194.10	07960	ARC INGALLS	0	1,077,924		194.10
200.00		TOTAL (SUM OF LINES 118-199)	-6,719,705	101,301,907		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Non-CMS W | Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	03950		76.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	UN-USED SQR FT - HOSPITAL	07950		194.00
194.01	MEALS ON WHEELS	07951		194.01
194.02	MARKETING	07952		194.02
194.03	GUEST MEALS	07953		194.03
194.04	PHYSICIAN/OTHER MEALS	07954		194.04
194.05	FOUNDATION	07955		194.05
194.06	DAYCARE CENTER	07956		194.06
194.07	UN-USED SQR FT - POB	07957		194.07
194.08	SENIOR SERVICES	07958		194.08
194.09	ARC BROMENN	07959		194.09
194.10	ARC INGALLS	07960		194.10
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/29/2013 5:13 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	262,870	399,387	1.00
2.00	SKILLED NURSING FACILITY	44.00	43,930	66,744	2.00
3.00	GUEST MEALS	194.03	8,780	13,340	3.00
4.00	PHYSICIAN/OTHER MEALS	194.04	110,213	167,450	4.00
5.00	DAYCARE CENTER	194.06	29,020	44,091	5.00
6.00	ARC BROMENN	194.09	55,051	83,640	6.00
	TOTALS		509,864	774,652	
	B - POB EXPENSE				
1.00	EMPLOYEE BENEFITS	4.00	0	29,637	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	18,561	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	84,612	3.00
4.00	OPERATION OF PLANT	7.00	0	90,444	4.00
5.00	HOUSEKEEPING	9.00	0	183,473	5.00
	TOTALS		0	406,727	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	293,868	48,839	1.00
	TOTALS		293,868	48,839	
	D - INSURANCE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	202,205	1.00
	TOTALS		0	202,205	
	E - BENEFITS				
1.00	EMPLOYEE BENEFITS	4.00	0	15,774	1.00
	TOTALS		0	15,774	
	F - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	68,299	1.00
	TOTALS		0	68,299	
	G - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,404,399	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	7,404,399	
	H - LEASE EXPENSE RECLASS				
1.00		0.00	0	0	1.00
2.00	PHARMACY	15.00	0	8,564	2.00
3.00	OPERATING ROOM	50.00	0	11,691	3.00
	TOTALS		0	20,255	
	I - IMPLANTIBLE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	11,213,720	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	11,213,720	
500.00	Grand Total: Increases		803,732	20,154,870	500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/29/2013 5:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	509,864	774,652	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		509,864	774,652			
	B - POB EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	406,727	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	406,727			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	293,868	48,839	0		1.00
	TOTALS		293,868	48,839			
	D - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	202,205	9		1.00
	TOTALS		0	202,205			
	E - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,774	0		1.00
	TOTALS		0	15,774			
	F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	0	68,299	0		1.00
	TOTALS		0	68,299			
	G - MED SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	102,870	0		1.00
2.00	PHARMACY	15.00	0	95,207	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	504,513	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	189,831	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	63,005	0		5.00
6.00	OPERATING ROOM	50.00	0	4,878,384	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	122,105	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	279,488	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	127,404	0		9.00
10.00	LABORATORY	60.00	0	180,986	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	99,073	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	128,674	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	227,017	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	64,758	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	4,459	0		15.00
16.00	CLINIC	90.00	0	366	0		16.00
17.00	EMERGENCY	91.00	0	336,259	0		17.00
	TOTALS		0	7,404,399			
	H - LEASE EXPENSE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,255	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	20,255			
	I - IMPLANTIBLE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	11,846	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3,435	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	774	0		3.00
4.00	OPERATING ROOM	50.00	0	7,795,427	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,875	0		5.00
7.00	PHYSICAL THERAPY	66.00	0	316,801	0		7.00
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,060,625	0		8.00
9.00	EMERGENCY	91.00	0	22,937	0		9.00
	TOTALS		0	11,213,720			
500.00	Grand Total: Decreases		803,732	20,154,870			500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/29/2013 5:13 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	262,870	DIETARY	10.00	509,864	1.00
2.00	SKILLED NURSING FACILITY	44.00	43,930		0.00	0	2.00
3.00	GUEST MEALS	194.03	8,780		0.00	0	3.00
4.00	PHYSICIAN/OTHER MEALS	194.04	110,213		0.00	0	4.00
5.00	DAYCARE CENTER	194.06	29,020		0.00	0	5.00
6.00	ARC BROMENN	194.09	55,051		0.00	0	6.00
	TOTALS		509,864	TOTALS		509,864	
	B - POB EXPENSE						
1.00	EMPLOYEE BENEFITS	4.00	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0		0.00	0	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0		0.00	0	3.00
4.00	OPERATION OF PLANT	7.00	0		0.00	0	4.00
5.00	HOUSEKEEPING	9.00	0		0.00	0	5.00
	TOTALS		0	TOTALS		0	
	C - NURSERY RECLASS						
1.00	NURSERY	43.00	293,868	ADULTS & PEDIATRICS	30.00	293,868	1.00
	TOTALS		293,868	TOTALS		293,868	
	D - INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	E - BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	F - DRUGS RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	EMPLOYEE BENEFITS	4.00	0	1.00
	TOTALS		0	TOTALS		0	
	G - MED SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00		0.00	0	PHARMACY	15.00	0	2.00
3.00		0.00	0	ADULTS & PEDIATRICS	30.00	0	3.00
4.00		0.00	0	INTENSIVE CARE UNIT	31.00	0	4.00
5.00		0.00	0	SKILLED NURSING FACILITY	44.00	0	5.00
6.00		0.00	0	OPERATING ROOM	50.00	0	6.00
7.00		0.00	0	DELIVERY ROOM & LABOR ROOM	52.00	0	7.00
8.00		0.00	0	ANESTHESIOLOGY	53.00	0	8.00
9.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0	9.00
10.00		0.00	0	LABORATORY	60.00	0	10.00
11.00		0.00	0	RESPIRATORY THERAPY	65.00	0	11.00
12.00		0.00	0	PHYSICAL THERAPY	66.00	0	12.00
13.00		0.00	0	ELECTROENCEPHALOGRAPHY	70.00	0	13.00
14.00		0.00	0	DRUGS CHARGED TO PATIENTS	73.00	0	14.00
15.00		0.00	0	CARDIAC REHABILITATION	76.97	0	15.00
16.00		0.00	0	CLINIC	90.00	0	16.00
17.00		0.00	0	EMERGENCY	91.00	0	17.00
	TOTALS		0	TOTALS		0	
	H - LEASE EXPENSE RECLASS						
1.00		0.00	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	PHARMACY	15.00	0		0.00	0	2.00
3.00	OPERATING ROOM	50.00	0		0.00	0	3.00
	TOTALS		0	TOTALS		0	
	I - IMPLANTIBLE RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	ADULTS & PEDIATRICS	30.00	0	1.00
2.00		0.00	0	INTENSIVE CARE UNIT	31.00	0	2.00
3.00		0.00	0	SKILLED NURSING FACILITY	44.00	0	3.00
4.00		0.00	0	OPERATING ROOM	50.00	0	4.00
5.00		0.00	0	DELIVERY ROOM & LABOR ROOM	52.00	0	5.00
7.00		0.00	0	PHYSICAL THERAPY	66.00	0	7.00
8.00		0.00	0	ELECTROENCEPHALOGRAPHY	70.00	0	8.00
9.00		0.00	0	EMERGENCY	91.00	0	9.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		803,732	Grand Total: Decreases		803,732	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	773,664	0	0	0	0	1.00
2.00	Land Improvements	11,159,042	416,584	0	416,584	0	2.00
3.00	Buildings and Fixtures	53,278,856	3,100,642	0	3,100,642	0	3.00
4.00	Building Improvements	429,739	0	0	0	0	4.00
5.00	Fixed Equipment	19,160,298	127,434	0	127,434	0	5.00
6.00	Movable Equipment	55,583,590	3,905,398	0	3,905,398	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	140,385,189	7,550,058	0	7,550,058	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	140,385,189	7,550,058	0	7,550,058	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	773,664	0	1.00
2.00	Land Improvements	11,575,626	0	2.00
3.00	Buildings and Fixtures	56,379,498	0	3.00
4.00	Building Improvements	429,739	0	4.00
5.00	Fixed Equipment	19,287,732	0	5.00
6.00	Movable Equipment	59,488,988	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147,935,247	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	147,935,247	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,533,557	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,839,062	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,372,619	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,533,557		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,839,062		2.00
3.00	Total (sum of lines 1-2)	0	8,372,619		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	88,446,259	0	88,446,259	0.597871	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	59,488,988	0	59,488,988	0.402129	0	2.00
3.00	Total (sum of lines 1-2)	147,935,247	0	147,935,247	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,450,683	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,832,064	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,282,747	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-287,670	-73,116	0	0	3,089,897	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,832,064	2.00
3.00	Total (sum of lines 1-2)	-287,670	-73,116	0	0	7,921,961	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,607,681			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	121,648			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	A&G - MISC REVENUE	B	-121,980	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	COLLECTION FEE REVENUE - PHYS	B	-348,932	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/29/2013 5:13 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	
33.02	CORPERATE WELLNESS	B	-23,343	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03			0		0.00	0	33.03
33.04	PLANT OP OTHER REV	B	-69,990	OPERATION OF PLANT	7.00	0	33.04
33.05	LAUNDRY REVENUE	B	-4,554	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	HEALTH PROMOTIONS	B	-420	NURSING ADMINISTRATION	13.00	0	33.06
33.07	SALE OF MEDICAL RECORDS	B	-1,818	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08			0		0.00	0	33.08
33.09	TRAINING FEES	B	-7,305	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	MISC INCOME -A&P	B	-14,071	ADULTS & PEDIATRICS	30.00	0	33.10
33.11			0		0.00	0	33.11
33.12	LABOR AND DELIVERY REVENUE	B	-3,390	DELIVERY ROOM & LABOR ROOM	52.00	0	33.12
33.13	RADIOLOGY - MISC REVENUE	B	-11,078	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	LAB - MISC REV	B	-10	LABORATORY	60.00	0	33.14
33.15			0		0.00	0	33.15
33.16	CARDIAC REHAB - MISC REV	B	-60,699	CARDIAC REHABILITATION	76.97	0	33.16
33.17	COUNSELING CTR MISC REV	B	-13,368	CLINIC	90.00	0	33.17
33.18	EMERGENCY ROOM - MISC REVENUE	B	-27,400	EMERGENCY	91.00	0	33.18
33.19	HHA - MISC REVENUE	B	-2,200	HOME HEALTH AGENCY	101.00	0	33.19
33.20	INVESTMENT PROPERTY TAXES	A	-114,000	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	ADVERTISING A&G	A	-819,266	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	MARKETING A&G	A	-2,265	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	MARKETING - FAMILY MATERNITY CENTER	A	-2,100	ADULTS & PEDIATRICS	30.00	0	33.23
33.24	MARKETING - PROCTOR HOME HEALTH	A	-403	HOME HEALTH AGENCY	101.00	0	33.24
33.25	MARKETING - CARDIAC REHAB	A	-600	CARDIAC REHABILITATION	76.97	0	33.25
33.26			0		0.00	0	33.26
33.27			0		0.00	0	33.27
33.28	MARKETING - EMERGENCY ROOM	A	-36	EMERGENCY	91.00	0	33.28
33.29	MARKETING - COMMUNITY OUTREACH	A	-271,808	CLINIC	90.00	0	33.29
33.30			0		0.00	0	33.30
33.31	ENTERTAINMENT EXPENSE	A	-20,721	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	ENTERTAINMENT EXPENSE	A	-30	NURSING ADMINISTRATION	13.00	0	33.32
33.33			0		0.00	0	33.33
33.34			0		0.00	0	33.34
33.35	ENTERTAINMENT EXPENSE	A	-2,193	EMERGENCY	91.00	0	33.35
33.36			0		0.00	0	33.36
33.37	INTEREST EXPENSE	A	-267,415	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.37
33.38			0		0.00	0	33.38
33.39	IHA DUES LOBBYING FFES	A	-30,220	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	POB SECURITY COST	A	-9,454	OPERATION OF PLANT	7.00	0	33.40
33.41	POB SECURITY COST	A	-2,449	EMPLOYEE BENEFITS	4.00	0	33.41
33.42	GRANT EXP OFFSET	A	-10,000	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	POB PROPERTY INSURANCE	A	-73,116	NEW CAP REL COSTS-BLDG & FIXT	1.00	12	33.43
33.44	SELF FUNDED INSURANCE	A	-1,849,629	EMPLOYEE BENEFITS	4.00	0	33.44
33.45	TELEPHONE SERVICES - SALARIES	A	-5,992	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	TELEPHONE SERVICES - BENEFITS	A	-1,569	EMPLOYEE BENEFITS	4.00	0	33.46
33.47	TELEPHONE SERVICES - EQUIPMENT	A	-2,576	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.47
33.48			0		0.00	0	33.48
33.49	PERSONAL USE OF VEHICLES	A	-4,422	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.49
33.50	MEDICAL STAFF OFFICER DUES	A	-32,850	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51			0		0.00	0	33.51
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,719,705				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-1 Date/Time Prepared: 5/29/2013 5:13 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	RENT EXPENSE	705,358	583,710	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	705,358	583,710	5.00

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

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

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

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

6.00	G	AFFILIATE	100.00	PROCTOR HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FOUNDATION				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-1 Date/Time Prepared: 5/29/2013 5:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	121,648	9		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	121,648			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	FOUNDATION		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2013 5:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	515,879	515,879	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	47,054	47,054	0	0	0	2.00
3.00	44.00	SKILLED NURSING FACILITY	1,000	1,000	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	186,327	186,327	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	60.00	LABORATORY	98,062	0	98,062	219,500	1,040	6.00
7.00	60.00	LABORATORY	109,648	109,648	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	20,000	20,000	0	0	0	8.00
9.00	76.97	CARDIAC REHABILITATION	9,167	9,167	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	90.00	CLINIC	28,560	28,560	0	0	0	11.00
12.00	90.00	CLINIC	49,460	49,460	0	0	0	12.00
13.00	90.00	CLINIC	83,190	83,190	0	0	0	13.00
14.00	90.00	CLINIC	27,460	27,460	0	0	0	14.00
15.00	91.00	EMERGENCY	1,410,103	1,410,103	0	0	0	15.00
16.00	91.00	EMERGENCY	53,833	53,833	0	0	0	16.00
17.00	30.00	ADULTS & PEDIATRICS	66,000	66,000	0	0	0	17.00
200.00			2,705,743	2,607,681	98,062		1,040	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	60.00	LABORATORY	109,750	5,488	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	90.00	CLINIC	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
17.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	17.00
200.00			109,750	5,488	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	30.00	ADULTS & PEDIATRICS	0	0	0	515,879		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	47,054		2.00
3.00	44.00	SKILLED NURSING FACILITY	0	0	0	1,000		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	186,327		4.00
5.00	0.00		0	0	0	0		5.00
6.00	60.00	LABORATORY	0	109,750	0	0		6.00
7.00	60.00	LABORATORY	0	0	0	109,648		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	20,000		8.00
9.00	76.97	CARDIAC REHABILITATION	0	0	0	9,167		9.00
10.00	0.00		0	0	0	0		10.00
11.00	90.00	CLINIC	0	0	0	28,560		11.00
12.00	90.00	CLINIC	0	0	0	49,460		12.00
13.00	90.00	CLINIC	0	0	0	83,190		13.00
14.00	90.00	CLINIC	0	0	0	27,460		14.00
15.00	91.00	EMERGENCY	0	0	0	1,410,103		15.00
16.00	91.00	EMERGENCY	0	0	0	53,833		16.00
17.00	30.00	ADULTS & PEDIATRICS	0	0	0	66,000		17.00
200.00			0	109,750	0	2,607,681		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,089,897	3,089,897				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,832,064		4,832,064			2.00
4.00	00400	EMPLOYEE BENEFITS	8,295,708	110,575	172,921	8,579,204		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,228,967	337,504	527,797	1,338,463	14,432,731	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,304,176	499,211	780,679	180	2,584,246	6.00
7.00	00700	OPERATION OF PLANT	1,809,107	35,541	55,580	236,693	2,136,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474,104	28,798	45,035	9,537	557,474	8.00
9.00	00900	HOUSEKEEPING	1,308,609	48,795	76,307	210,311	1,644,022	9.00
10.00	01000	DIETARY	620,047	38,228	59,782	54,602	772,659	10.00
11.00	01100	CAFETERIA	662,257	108,570	169,784	58,319	998,930	11.00
13.00	01300	NURSING ADMINISTRATION	825,047	17,497	27,363	153,570	1,023,477	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	201,269	0	0	50,690	251,959	14.00
15.00	01500	PHARMACY	1,506,027	24,667	38,575	248,559	1,817,828	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,081,083	27,661	43,256	177,693	3,329,693	16.00
17.00	01700	SOCIAL SERVICE	168,054	1,070	1,674	32,249	203,047	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,940,398	457,666	715,710	1,448,447	9,562,221	30.00
31.00	03100	INTENSIVE CARE UNIT	2,034,172	68,096	106,491	404,260	2,613,019	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	342,707	8,569	13,401	65,196	429,873	43.00
44.00	04400	SKILLED NURSING FACILITY	1,220,509	121,225	189,575	244,673	1,775,982	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,142,743	316,287	494,617	1,023,238	7,976,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	943,062	24,809	38,797	194,077	1,200,745	52.00
53.00	05300	ANESTHESIOLOGY	139,652	5,186	8,111	10,826	163,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,492,064	205,090	320,725	377,737	4,395,616	54.00
60.00	06000	LABORATORY	4,179,996	87,166	136,312	357,740	4,761,214	60.00
65.00	06500	RESPIRATORY THERAPY	1,308,598	31,784	49,705	250,292	1,640,379	65.00
66.00	06600	PHYSICAL THERAPY	2,075,261	35,085	54,866	52,345	2,217,557	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,247,002	65,814	102,921	230,201	3,645,938	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,404,399	84,396	131,981	0	7,620,776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,213,720	0	0	0	11,213,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,661,599	0	0	0	2,661,599	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	238,896	18,149	28,381	40,544	325,970	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,734,003	63,127	98,720	281,150	3,177,000	90.00
91.00	09100	EMERGENCY	775,974	86,185	134,779	462,189	1,459,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	709,088	5,688	8,895	92,249	815,920	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,210,259	2,962,439	4,632,740	8,106,030	97,410,303	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,932	53,064	0	86,996	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,549	2,423	0	3,972	194.02
194.03	07953	GUEST MEALS	22,120	0	0	1,948	24,068	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	277,663	0	0	24,451	302,114	194.04
194.05	07955	FOUNDATION	0	19,615	30,675	0	50,290	194.05
194.06	07956	DAYCARE CENTER	535,276	68,523	107,158	94,749	805,706	194.06
194.07	07957	UN-USED SQR FT - POB	0	3,839	6,004	0	9,843	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	1,178,665	0	0	165,663	1,344,328	194.09
194.10	07960	ARC INGALLS	1,077,924	0	0	186,363	1,264,287	194.10
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	101,301,907	3,089,897	4,832,064	8,579,204	101,301,907	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,432,731					5.00
6.00	00600	MAINTENANCE & REPAIRS	429,354	3,013,600				6.00
7.00	00700	OPERATION OF PLANT	355,034	49,989	2,541,944			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,620	40,505	34,742	725,341		8.00
9.00	00900	HOUSEKEEPING	273,143	68,631	58,866	0	2,044,662	9.00
10.00	01000	DIETARY	128,372	53,768	46,118	0	38,514	10.00
11.00	01100	CAFETERIA	165,965	152,704	130,977	0	109,382	11.00
13.00	01300	NURSING ADMINISTRATION	170,044	24,610	21,109	0	17,628	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,861	0	0	0	0	14.00
15.00	01500	PHARMACY	302,019	34,694	29,758	0	24,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	553,205	38,905	33,370	0	27,868	16.00
17.00	01700	SOCIAL SERVICE	33,735	1,505	1,291	0	1,078	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,588,696	643,714	552,121	530,053	461,092	30.00
31.00	03100	INTENSIVE CARE UNIT	434,135	95,778	82,151	59,896	68,606	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	71,420	12,053	10,338	30,090	8,633	43.00
44.00	04400	SKILLED NURSING FACILITY	295,067	170,504	146,245	105,302	122,132	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,325,304	444,860	381,565	0	318,654	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	199,495	34,894	29,930	0	24,995	52.00
53.00	05300	ANESTHESIOLOGY	27,210	7,295	6,257	0	5,225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,301	288,461	247,418	0	206,625	54.00
60.00	06000	LABORATORY	791,042	122,599	105,156	0	87,818	60.00
65.00	06500	RESPIRATORY THERAPY	272,537	44,705	38,344	0	32,022	65.00
66.00	06600	PHYSICAL THERAPY	368,432	49,347	42,326	0	35,347	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	605,747	92,568	79,397	0	66,306	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,266,139	118,704	101,815	0	85,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,863,109	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	442,206	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	54,158	25,526	21,894	0	18,284	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	527,836	88,789	76,156	0	63,600	90.00
91.00	09100	EMERGENCY	242,424	121,220	103,973	0	86,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	135,559	8,000	6,862	0	5,730	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,786,169	2,834,328	2,388,179	725,341	1,916,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,454	47,726	40,935	0	34,186	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	660	2,179	1,869	0	1,561	194.02
194.03	07953	GUEST MEALS	3,999	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	50,194	0	0	0	0	194.04
194.05	07955	FOUNDATION	8,355	27,589	23,664	0	19,762	194.05
194.06	07956	DAYCARE CENTER	133,862	96,378	82,665	0	69,036	194.06
194.07	07957	UN-USED SQR FT - POB	1,635	5,400	4,632	0	3,868	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	223,351	0	0	0	0	194.09
194.10	07960	ARC INGALLS	210,052	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,432,731	3,013,600	2,541,944	725,341	2,044,662	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,039,431					10.00
11.00	01100	CAFETERIA	0	1,557,958				11.00
13.00	01300	NURSING ADMINISTRATION	0	39,546	1,296,414			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,053	0	306,873		14.00
15.00	01500	PHARMACY	0	64,007	0	3,987	2,277,145	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,758	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,304	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	933,901	372,986	434,325	21,130	3,340	30.00
31.00	03100	INTENSIVE CARE UNIT	105,530	104,102	121,223	7,951	679	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	16,789	19,550	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	63,132	73,515	2,639	983	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	263,496	306,832	204,318	3,787	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,977	58,197	5,114	589	52.00
53.00	05300	ANESTHESIOLOGY	0	2,788	3,246	11,706	778	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,272	113,270	5,336	58,238	54.00
60.00	06000	LABORATORY	0	92,122	0	7,580	3,113	60.00
65.00	06500	RESPIRATORY THERAPY	0	64,453	0	4,149	2,514	65.00
66.00	06600	PHYSICAL THERAPY	0	13,480	0	5,389	6,066	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	59,279	0	9,293	57,149	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,712	2,136,702	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	10,441	0	187	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	345	219	90.00
91.00	09100	EMERGENCY	0	119,019	138,594	14,083	1,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	23,755	27,662	786	1,279	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,039,431	1,523,759	1,296,414	306,705	2,277,145	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	2,544	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	6,281	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	25,374	0	69	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	64	0	194.09
194.10	07960	ARC INGALLS	0	0	0	35	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,039,431	1,557,958	1,296,414	306,873	2,277,145	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	4,028,799					16.00
17.00	01700	SOCIAL SERVICE	0	248,960				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	362,959	189,805	15,656,343	0	15,656,343	30.00
31.00	03100	INTENSIVE CARE UNIT	77,317	21,448	3,791,835	0	3,791,835	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	10,555	0	609,301	0	609,301	43.00
44.00	04400	SKILLED NURSING FACILITY	29,297	37,707	2,822,505	0	2,822,505	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	806,711	0	12,032,412	0	12,032,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,198	0	1,629,134	0	1,629,134	52.00
53.00	05300	ANESTHESIOLOGY	172,298	0	400,578	0	400,578	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	515,543	0	6,658,080	0	6,658,080	54.00
60.00	06000	LABORATORY	356,654	0	6,327,298	0	6,327,298	60.00
65.00	06500	RESPIRATORY THERAPY	98,208	0	2,197,311	0	2,197,311	65.00
66.00	06600	PHYSICAL THERAPY	113,820	0	2,851,764	0	2,851,764	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	336,982	0	4,952,659	0	4,952,659	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	219,186	0	9,411,648	0	9,411,648	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	291,227	0	13,368,056	0	13,368,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,455	0	5,515,674	0	5,515,674	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,822	0	460,282	0	460,282	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	91,735	0	4,025,680	0	4,025,680	90.00
91.00	09100	EMERGENCY	232,874	0	2,519,853	0	2,519,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	11,958	0	1,037,511	0	1,037,511	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,028,799	248,960	96,267,924	0	96,267,924	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	224,297	0	224,297	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	10,241	0	10,241	194.02
194.03	07953	GUEST MEALS	0	0	30,611	0	30,611	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	358,589	0	358,589	194.04
194.05	07955	FOUNDATION	0	0	129,660	0	129,660	194.05
194.06	07956	DAYCARE CENTER	0	0	1,213,090	0	1,213,090	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	25,378	0	25,378	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,567,743	0	1,567,743	194.09
194.10	07960	ARC INGALLS	0	0	1,474,374	0	1,474,374	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,028,799	248,960	101,301,907	0	101,301,907	202.00

COST ALLOCATION STATISTICS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Non-CMS W | Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS	2	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-3	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	5	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	7	PATIENT DAYS	10.00
11.00	CAFETERIA	8	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	9	NURSING SALARIES	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQUIS.	14.00
15.00	PHARMACY	11	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	13	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	110,575	172,921	283,496	283,496	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	337,504	527,797	865,301	44,229	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	499,211	780,679	1,279,890	6	6.00
7.00	00700	OPERATION OF PLANT	0	35,541	55,580	91,121	7,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,798	45,035	73,833	315	8.00
9.00	00900	HOUSEKEEPING	0	48,795	76,307	125,102	6,950	9.00
10.00	01000	DIETARY	0	38,228	59,782	98,010	1,804	10.00
11.00	01100	CAFETERIA	0	108,570	169,784	278,354	1,927	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,497	27,363	44,860	5,075	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,675	14.00
15.00	01500	PHARMACY	0	24,667	38,575	63,242	8,213	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,661	43,256	70,917	5,872	16.00
17.00	01700	SOCIAL SERVICE	0	1,070	1,674	2,744	1,066	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	457,666	715,710	1,173,376	47,866	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,096	106,491	174,587	13,358	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	8,569	13,401	21,970	2,154	43.00
44.00	04400	SKILLED NURSING FACILITY	0	121,225	189,575	310,800	8,085	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	316,287	494,617	810,904	33,812	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,809	38,797	63,606	6,413	52.00
53.00	05300	ANESTHESIOLOGY	0	5,186	8,111	13,297	358	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	205,090	320,725	525,815	12,482	54.00
60.00	06000	LABORATORY	0	87,166	136,312	223,478	11,821	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,784	49,705	81,489	8,271	65.00
66.00	06600	PHYSICAL THERAPY	0	35,085	54,866	89,951	1,730	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	65,814	102,921	168,735	7,607	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,396	131,981	216,377	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	18,149	28,381	46,530	1,340	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	63,127	98,720	161,847	9,290	90.00
91.00	09100	EMERGENCY	0	86,185	134,779	220,964	15,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,688	8,895	14,583	3,048	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,962,439	4,632,740	7,595,179	267,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,932	53,064	86,996	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,549	2,423	3,972	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	64	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	808	194.04
194.05	07955	FOUNDATION	0	19,615	30,675	50,290	0	194.05
194.06	07956	DAYCARE CENTER	0	68,523	107,158	175,681	3,131	194.06
194.07	07957	UN-USED SQR FT - POB	0	3,839	6,004	9,843	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	5,474	194.09
194.10	07960	ARC INGALLS	0	0	0	0	6,158	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,089,897	4,832,064	7,921,961	283,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	909,530					5.00
6.00	00600	MAINTENANCE & REPAIRS	27,057	1,306,953				6.00
7.00	00700	OPERATION OF PLANT	22,374	21,680	142,996			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,837	17,566	1,954	99,505		8.00
9.00	00900	HOUSEKEEPING	17,213	29,764	3,311	0	182,340	9.00
10.00	01000	DIETARY	8,090	23,318	2,594	0	3,435	10.00
11.00	01100	CAFETERIA	10,459	66,226	7,368	0	9,755	11.00
13.00	01300	NURSING ADMINISTRATION	10,716	10,673	1,187	0	1,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,638	0	0	0	0	14.00
15.00	01500	PHARMACY	19,033	15,046	1,674	0	2,216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,862	16,873	1,877	0	2,485	16.00
17.00	01700	SOCIAL SERVICE	2,126	653	73	0	96	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100,116	279,170	31,061	72,714	41,118	30.00
31.00	03100	INTENSIVE CARE UNIT	27,358	41,538	4,621	8,217	6,118	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	4,501	5,227	582	4,128	770	43.00
44.00	04400	SKILLED NURSING FACILITY	18,595	73,945	8,227	14,446	10,892	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	83,518	192,929	21,465	0	28,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,572	15,133	1,684	0	2,229	52.00
53.00	05300	ANESTHESIOLOGY	1,715	3,164	352	0	466	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,022	125,101	13,918	0	18,427	54.00
60.00	06000	LABORATORY	49,850	53,169	5,915	0	7,831	60.00
65.00	06500	RESPIRATORY THERAPY	17,175	19,388	2,157	0	2,856	65.00
66.00	06600	PHYSICAL THERAPY	23,218	21,401	2,381	0	3,152	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,173	40,145	4,466	0	5,913	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,790	51,480	5,728	0	7,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	117,413	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,867	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,413	11,070	1,232	0	1,631	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,263	38,506	4,284	0	5,672	90.00
91.00	09100	EMERGENCY	15,277	52,571	5,849	0	7,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,543	3,469	386	0	511	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	868,784	1,229,205	134,346	99,505	170,888	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	911	20,698	2,303	0	3,049	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	42	945	105	0	139	194.02
194.03	07953	GUEST MEALS	252	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	3,163	0	0	0	0	194.04
194.05	07955	FOUNDATION	527	11,965	1,331	0	1,762	194.05
194.06	07956	DAYCARE CENTER	8,436	41,798	4,650	0	6,157	194.06
194.07	07957	UN-USED SQR FT - POB	103	2,342	261	0	345	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	14,075	0	0	0	0	194.09
194.10	07960	ARC INGALLS	13,237	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	909,530	1,306,953	142,996	99,505	182,340	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	137,251					10.00
11.00	01100	CAFETERIA	0	374,089				11.00
13.00	01300	NURSING ADMINISTRATION	0	9,496	83,579			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,134	0	7,447		14.00
15.00	01500	PHARMACY	0	15,369	0	97	124,890	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,987	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,994	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	123,316	89,557	28,000	513	183	30.00
31.00	03100	INTENSIVE CARE UNIT	13,935	24,997	7,815	193	37	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	4,031	1,260	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	15,159	4,740	64	54	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	63,270	19,782	4,957	208	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,000	3,752	124	32	52.00
53.00	05300	ANESTHESIOLOGY	0	669	209	284	43	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,357	7,303	129	3,194	54.00
60.00	06000	LABORATORY	0	22,120	0	184	171	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,476	0	101	138	65.00
66.00	06600	PHYSICAL THERAPY	0	3,237	0	131	333	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,234	0	225	3,134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	66	117,187	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,507	0	5	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	8	12	90.00
91.00	09100	EMERGENCY	0	28,579	8,935	342	94	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,704	1,783	19	70	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	137,251	365,877	83,579	7,442	124,890	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	611	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	1,508	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	6,093	0	2	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	2	0	194.09
194.10	07960	ARC INGALLS	0	0	0	1	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	137,251	374,089	83,579	7,447	124,890	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	143,873					16.00
17.00	01700	SOCIAL SERVICE	0	8,752				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,951	6,672	2,006,613	0	2,006,613	30.00
31.00	03100	INTENSIVE CARE UNIT	2,759	754	326,287	0	326,287	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	377	0	45,000	0	45,000	43.00
44.00	04400	SKILLED NURSING FACILITY	1,045	1,326	467,378	0	467,378	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,905	0	1,288,167	0	1,288,167	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	899	0	118,444	0	118,444	52.00
53.00	05300	ANESTHESIOLOGY	6,148	0	26,705	0	26,705	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,395	0	794,143	0	794,143	54.00
60.00	06000	LABORATORY	12,726	0	387,265	0	387,265	60.00
65.00	06500	RESPIRATORY THERAPY	3,504	0	150,555	0	150,555	65.00
66.00	06600	PHYSICAL THERAPY	4,061	0	149,595	0	149,595	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,024	0	294,656	0	294,656	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,821	0	368,779	0	368,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,391	0	127,804	0	127,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,722	0	154,842	0	154,842	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	136	0	67,864	0	67,864	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,273	0	256,155	0	256,155	90.00
91.00	09100	EMERGENCY	8,309	0	363,936	0	363,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	427	0	38,543	0	38,543	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,873	8,752	7,432,731	0	7,432,731	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	113,957	0	113,957	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	5,203	0	5,203	194.02
194.03	07953	GUEST MEALS	0	0	927	0	927	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	5,479	0	5,479	194.04
194.05	07955	FOUNDATION	0	0	65,875	0	65,875	194.05
194.06	07956	DAYCARE CENTER	0	0	245,948	0	245,948	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	12,894	0	12,894	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	19,551	0	19,551	194.09
194.10	07960	ARC INGALLS	0	0	19,396	0	19,396	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	143,873	8,752	7,921,961	0	7,921,961	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	412,870					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		412,870				2.00
4.00	00400	EMPLOYEE BENEFITS	14,775	14,775	38,670,455			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,097	45,097	6,033,080	-14,432,731	86,869,176	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	810	0	2,584,246	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,066,887	0	2,136,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	42,988	0	557,474	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	947,972	0	1,644,022	9.00
10.00	01000	DIETARY	5,108	5,108	246,115	0	772,659	10.00
11.00	01100	CAFETERIA	14,507	14,507	262,870	0	998,930	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	692,213	0	1,023,477	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	228,485	0	251,959	14.00
15.00	01500	PHARMACY	3,296	3,296	1,120,370	0	1,817,828	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,696	3,696	800,947	0	3,329,693	16.00
17.00	01700	SOCIAL SERVICE	143	143	145,360	0	203,047	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,153	61,153	6,528,786	0	9,562,221	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,822,190	0	2,613,019	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,145	1,145	293,868	0	429,873	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	1,102,858	0	1,775,982	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	4,612,215	0	7,976,885	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,315	3,315	874,798	0	1,200,745	52.00
53.00	05300	ANESTHESIOLOGY	693	693	48,797	0	163,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,702,640	0	4,395,616	54.00
60.00	06000	LABORATORY	11,647	11,647	1,612,500	0	4,761,214	60.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	1,128,183	0	1,640,379	65.00
66.00	06600	PHYSICAL THERAPY	4,688	4,688	235,945	0	2,217,557	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	1,037,624	0	3,645,938	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,277	11,277	0	0	7,620,776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	11,213,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,661,599	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,425	2,425	182,750	0	325,970	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,435	8,435	1,267,274	0	3,177,000	90.00
91.00	09100	EMERGENCY	11,516	11,516	2,083,303	0	1,459,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	760	760	415,808	0	815,920	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	395,839	395,839	36,537,636	-14,432,731	82,977,572	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	86,996	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	207	207	0	0	3,972	194.02
194.03	07953	GUEST MEALS	0	0	8,780	0	24,068	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	110,213	0	302,114	194.04
194.05	07955	FOUNDATION	2,621	2,621	0	0	50,290	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	427,079	0	805,706	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	9,843	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	746,721	0	1,344,328	194.09
194.10	07960	ARC INGALLS	0	0	840,026	0	1,264,287	194.10
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)	3,089,897	4,832,064	8,579,204		14,432,731	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.483947	11.703597	0.221854		0.166143	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			283,496		909,530	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.007331		0.010470	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	286,294					6.00
7.00	00700	OPERATION OF PLANT	4,749	281,545				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	30,687			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	271,177		9.00
10.00	01000	DIETARY	5,108	5,108	0	5,108	24,959	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	0	2,338	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,696	3,696	0	3,696	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,153	61,153	22,425	61,153	22,425	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	2,534	9,099	2,534	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,145	1,145	1,273	1,145	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	4,455	16,198	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,315	3,315	0	3,315	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	4,688	4,688	0	4,688	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,277	11,277	0	11,277	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,425	2,425	0	2,425	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,435	8,435	0	8,435	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	760	760	0	760	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	269,263	264,514	30,687	254,146	24,959	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	207	207	0	207	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,621	2,621	0	2,621	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	3,013,600	2,541,944	725,341	2,044,662	1,039,431	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.526242	9.028553	23.636752	7.539954	41.645539	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,306,953	142,996	99,505	182,340	137,251	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.565073	0.507897	3.242578	0.672402	5.499058	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	27,270,453					11.00
13.00	01300	NURSING ADMINISTRATION	692,213	19,487,461				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	228,485	0	7,327,046			14.00
15.00	01500	PHARMACY	1,120,370	0	95,207	2,836,701		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	800,947	0	0	0	372,430,611	16.00
17.00	01700	SOCIAL SERVICE	145,360	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,528,786	6,528,786	504,513	4,161	33,551,436	30.00
31.00	03100	INTENSIVE CARE UNIT	1,822,190	1,822,190	189,831	846	7,147,097	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	293,868	293,868	0	0	975,697	43.00
44.00	04400	SKILLED NURSING FACILITY	1,105,056	1,105,056	63,005	1,224	2,708,147	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,612,215	4,612,215	4,878,384	4,718	74,585,601	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	874,798	874,798	122,105	734	2,329,249	52.00
53.00	05300	ANESTHESIOLOGY	48,797	48,797	279,488	969	15,926,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,702,640	1,702,640	127,404	72,549	47,656,021	54.00
60.00	06000	LABORATORY	1,612,500	0	180,986	3,878	32,968,589	60.00
65.00	06500	RESPIRATORY THERAPY	1,128,183	0	99,073	3,132	9,078,169	65.00
66.00	06600	PHYSICAL THERAPY	235,945	0	128,674	7,557	10,521,340	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,037,624	0	221,889	71,192	31,150,101	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	20,261,242	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	26,920,598	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	64,758	2,661,746	25,185,369	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	182,750	0	4,459	0	353,332	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	8,228	273	8,479,824	90.00
91.00	09100	EMERGENCY	2,083,303	2,083,303	336,259	2,129	21,526,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	415,808	415,808	18,775	1,593	1,105,350	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,671,838	19,487,461	7,323,038	2,836,701	372,430,611	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	44,536	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	109,939	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	444,140	0	1,638	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,527	0	0	194.09
194.10	07960	ARC INGALLS	0	0	843	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,557,958	1,296,414	306,873	2,277,145	4,028,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.057130	0.066526	0.041882	0.802744	0.010818	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	374,089	83,579	7,447	124,890	143,873	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.013718	0.004289	0.001016	0.044026	0.000386	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 5:13 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
17.00	01700	SOCIAL SERVICE	29,414		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	22,425		30.00
31.00	03100	INTENSIVE CARE UNIT	2,534		31.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,455		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,414		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	07951	MEALS ON WHEELS	0		194.01
194.02	07952	MARKETING	0		194.02
194.03	07953	GUEST MEALS	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0		194.04
194.05	07955	FOUNDATION	0		194.05
194.06	07956	DAYCARE CENTER	0		194.06
194.07	07957	UN-USED SQR FT - POB	0		194.07
194.08	07958	SENIOR SERVICES	0		194.08
194.09	07959	ARC BROMENN	0		194.09
194.10	07960	ARC INGALLS	0		194.10
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)	248,960		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.463997		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,752		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.297545		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 5:13 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,656,343		15,656,343	0	15,656,343	31,885,835	30.00
31.00	03100	INTENSIVE CARE UNIT	3,791,835		3,791,835	0	3,791,835	7,147,097	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	0	40.00
43.00	04300	NURSERY	609,301		609,301	0	609,301	975,697	43.00
44.00	04400	SKILLED NURSING FACILITY	2,822,505		2,822,505	0	2,822,505	2,708,147	44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,032,412		12,032,412	0	12,032,412	24,874,070	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,629,134		1,629,134	0	1,629,134	2,133,352	52.00
53.00	05300	ANESTHESIOLOGY	400,578		400,578	0	400,578	8,237,305	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,658,080		6,658,080	0	6,658,080	7,402,654	54.00
60.00	06000	LABORATORY	6,327,298		6,327,298	0	6,327,298	10,527,204	60.00
65.00	06500	RESPIRATORY THERAPY	2,197,311	0	2,197,311	0	2,197,311	4,916,024	65.00
66.00	06600	PHYSICAL THERAPY	2,851,764	0	2,851,764	0	2,851,764	6,401,354	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,952,659		4,952,659	0	4,952,659	12,209,624	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,411,648		9,411,648	0	9,411,648	13,853,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,368,056		13,368,056	0	13,368,056	18,316,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,515,674		5,515,674	0	5,515,674	17,425,131	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	460,282		460,282	0	460,282	2,368	76.97
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,025,680		4,025,680	0	4,025,680	701	90.00
91.00	09100	EMERGENCY	2,519,853		2,519,853	0	2,519,853	5,867,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,262,918		1,262,918		1,262,918	232,280	92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,037,511		1,037,511		1,037,511	0	101.00
200.00		Subtotal (see instructions)	97,530,842	0	97,530,842	0	97,530,842	175,115,916	200.00
201.00		Less Observation Beds	1,262,918		1,262,918		1,262,918		201.00
202.00		Total (see instructions)	96,267,924	0	96,267,924	0	96,267,924	175,115,916	202.00

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		31,885,835					30.00
31.00	03100	INTENSIVE CARE UNIT		7,147,097					31.00
40.00	04000	SUBPROVIDER - IPF		0					40.00
43.00	04300	NURSERY		975,697					43.00
44.00	04400	SKILLED NURSING FACILITY		2,708,147					44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	49,711,531	74,585,601	0.161324	0.000000	0.161324		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	195,897	2,329,249	0.699425	0.000000	0.699425		52.00
53.00	05300	ANESTHESIOLOGY	7,689,646	15,926,951	0.025151	0.000000	0.025151		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,253,367	47,656,021	0.139711	0.000000	0.139711		54.00
60.00	06000	LABORATORY	22,441,385	32,968,589	0.191919	0.000000	0.191919		60.00
65.00	06500	RESPIRATORY THERAPY	4,162,145	9,078,169	0.242043	0.000000	0.242043		65.00
66.00	06600	PHYSICAL THERAPY	4,119,986	10,521,340	0.271046	0.000000	0.271046		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,940,477	31,150,101	0.158993	0.000000	0.158993		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,407,877	20,261,242	0.464515	0.000000	0.464515		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,604,050	26,920,598	0.496574	0.000000	0.496574		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,760,238	25,185,369	0.219003	0.000000	0.219003		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	350,964	353,332	1.302690	0.000000	1.302690		76.97
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,479,123	8,479,824	0.474736	0.000000	0.474736		90.00
91.00	09100	EMERGENCY	15,659,338	21,526,498	0.117058	0.000000	0.117058		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,433,321	1,665,601	0.758236	0.000000	0.758236		92.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 5:13 pm

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		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,105,350	1,105,350					101.00
200.00		Subtotal (see instructions)	197,314,695	372,430,611					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	197,314,695	372,430,611					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part I Date/Time Prepared: 5/29/2013 5:13 pm

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,006,613	0	2,006,613	24,174	83.01	30.00
31.00	INTENSIVE CARE UNIT	326,287		326,287	2,533	128.81	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	45,000		45,000	1,273	35.35	43.00
44.00	SKILLED NURSING FACILITY	467,378		467,378	4,450	105.03	44.00
200.00	Total (lines 30-199)	2,845,278		2,845,278	32,430		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	11,988	995,124		30.00
31.00	INTENSIVE CARE UNIT	1,402	180,592		31.00
40.00	SUBPROVIDER - IPF	0	0		40.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	3,231	339,352		44.00
200.00	Total (lines 30-199)	16,621	1,515,068		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		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	1,288,167	74,585,601	0.017271	11,529,072	199,119	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	118,444	2,329,249	0.050851	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,705	15,926,951	0.001677	3,402,846	5,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	794,143	47,656,021	0.016664	6,970,288	116,153	54.00
60.00	06000	LABORATORY	387,265	32,968,589	0.011746	6,866,805	80,657	60.00
65.00	06500	RESPIRATORY THERAPY	150,555	9,078,169	0.016584	2,756,751	45,718	65.00
66.00	06600	PHYSICAL THERAPY	149,595	10,521,340	0.014218	2,294,293	32,620	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	294,656	31,150,101	0.009459	6,785,951	64,188	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	368,779	20,261,242	0.018201	6,416,025	116,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	127,804	26,920,598	0.004747	9,408,650	44,663	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	154,842	25,185,369	0.006148	8,654,270	53,206	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	67,864	353,332	0.192069	1,263	243	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	256,155	8,479,824	0.030208	0	0	90.00
91.00	09100	EMERGENCY	363,936	21,526,498	0.016906	3,594,152	60,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	161,863	1,665,601	0.097180	135,350	13,153	92.00
200.00		Total (lines 50-199)	4,710,773	328,608,485		68,815,716	832,968	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part III Date/Time Prepared: 5/29/2013 5:13 pm

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,174	0.00	11,988	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,533	0.00	1,402	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	0	40.00
43.00	04300	NURSERY	1,273	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,450	0.00	3,231	0	0	44.00
200.00		Total (lines 30-199)	32,430		16,621	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
			12.00	13.00	
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	74,585,601	0.000000	0.000000	11,529,072	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,329,249	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	15,926,951	0.000000	0.000000	3,402,846	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,656,021	0.000000	0.000000	6,970,288	54.00
60.00	06000	LABORATORY	0	32,968,589	0.000000	0.000000	6,866,805	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,078,169	0.000000	0.000000	2,756,751	65.00
66.00	06600	PHYSICAL THERAPY	0	10,521,340	0.000000	0.000000	2,294,293	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31,150,101	0.000000	0.000000	6,785,951	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,261,242	0.000000	0.000000	6,416,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	26,920,598	0.000000	0.000000	9,408,650	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,185,369	0.000000	0.000000	8,654,270	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	353,332	0.000000	0.000000	1,263	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,479,824	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	21,526,498	0.000000	0.000000	3,594,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,665,601	0.000000	0.000000	135,350	92.00
200.00		Total (lines 50-199)	0	328,608,485			68,815,716	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,649,851	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	407	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,254,903	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,233,586	0	0	0	54.00
60.00	06000	LABORATORY	0	1,155,316	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,233,903	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,680,368	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,769,728	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,738,943	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,219,711	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,934,206	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	198,850	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	202,640	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,009,840	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	550,299	0	0	0	92.00
200.00		Total (lines 50-199)	0	49,832,551	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.161324	11,649,851	0	0	1,879,401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699425	407	0	0	285	52.00
53.00	05300	ANESTHESIOLOGY	0.025151	1,254,903	0	0	31,562	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139711	12,233,586	0	0	1,709,167	54.00
60.00	06000	LABORATORY	0.191919	1,155,316	0	0	221,727	60.00
65.00	06500	RESPIRATORY THERAPY	0.242043	1,233,903	0	0	298,658	65.00
66.00	06600	PHYSICAL THERAPY	0.271046	1,680,368	0	0	455,457	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.158993	8,769,728	0	0	1,394,325	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464515	1,738,943	0	0	807,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.496574	3,219,711	0	0	1,598,825	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219003	1,934,206	0	21,189	423,597	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.302690	198,850	0	0	259,040	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.474736	202,640	0	0	96,201	90.00
91.00	09100	EMERGENCY	0.117058	4,009,840	0	0	469,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.758236	550,299	0	0	417,257	92.00
200.00		Subtotal (see instructions)		49,832,551	0	21,189	10,062,651	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,832,551	0	21,189	10,062,651	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,640		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	4,640		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,640		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		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	74,585,601	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,329,249	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	15,926,951	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,656,021	0.000000	0.000000	78,608	54.00
60.00	06000	LABORATORY	0	32,968,589	0.000000	0.000000	215,415	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,078,169	0.000000	0.000000	313,065	65.00
66.00	06600	PHYSICAL THERAPY	0	10,521,340	0.000000	0.000000	1,888,009	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31,150,101	0.000000	0.000000	38,657	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,261,242	0.000000	0.000000	260,319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	26,920,598	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,185,369	0.000000	0.000000	844,773	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	353,332	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,479,824	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	21,526,498	0.000000	0.000000	289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,665,601	0.000000	0.000000	472	92.00
200.00		Total (lines 50-199)	0	328,608,485			3,639,607	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.161324	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699425	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025151	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139711	0	0	0	0	54.00
60.00	06000	LABORATORY	0.191919	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.242043	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.271046	0	0	0	0	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.158993	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464515	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.496574	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219003	0	0	1,000	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.302690	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.474736	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.117058	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.758236	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	1,000	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	1,000	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	219		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	219		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	219		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,174	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,174	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)	22,224	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11,988	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,656,343	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,656,343	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	34,481,478	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	34,481,478	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.454051	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)	1,551.54	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)	15,656,343	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)	647.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,764,028	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)	7,764,028	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,791,835	2,533	1,496.97	1,402	2,098,752	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)	16,677,965	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,540,745	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)	1,175,716	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	832,968	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,008,684	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,532,061	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)	1,950	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	647.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,262,918	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

	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	2,006,613	15,656,343	0.128166	1,262,918	161,863	90.00
91.00	Nursing School cost	0	15,656,343	0.000000	1,262,918	0	91.00
92.00	Allied health cost	0	15,656,343	0.000000	1,262,918	0	92.00
93.00	All other Medical Education	0	15,656,343	0.000000	1,262,918	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 5:13 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,450	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)	4,450	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,231	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,822,505	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,822,505	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,822,505	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,822,505	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	634.27	71.00
72.00	Program routine service cost (line 9 x line 71)	2,049,326	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,049,326	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,049,326	83.00
84.00	Program inpatient ancillary services (see instructions)	952,304	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,001,630	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

	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: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		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		12,547,140		30.00
31.00	03100	INTENSIVE CARE UNIT		3,545,811		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.161324	11,529,072	1,859,916	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699425	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025151	3,402,846	85,585	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139711	6,970,288	973,826	54.00
60.00	06000	LABORATORY	0.191919	6,866,805	1,317,870	60.00
65.00	06500	RESPIRATORY THERAPY	0.242043	2,756,751	667,252	65.00
66.00	06600	PHYSICAL THERAPY	0.271046	2,294,293	621,859	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.158993	6,785,951	1,078,919	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464515	6,416,025	2,980,340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.496574	9,408,650	4,672,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219003	8,654,270	1,895,311	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.302690	1,263	1,645	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.474736	0	0	90.00
91.00	09100	EMERGENCY	0.117058	3,594,152	420,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.758236	135,350	102,627	92.00
200.00		Total (sum of lines 50-94 and 96-98)		68,815,716	16,677,965	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)		68,815,716		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.161324	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.699425	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025151	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139711	78,608	10,982	54.00
60.00	06000	LABORATORY	0.191919	215,415	41,342	60.00
65.00	06500	RESPIRATORY THERAPY	0.242043	313,065	75,775	65.00
66.00	06600	PHYSICAL THERAPY	0.271046	1,888,009	511,737	66.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.158993	38,657	6,146	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464515	260,319	120,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.496574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219003	844,773	185,008	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.302690	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.474736	0	0	90.00
91.00	09100	EMERGENCY	0.117058	289	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.758236	472	358	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,639,607	952,304	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)		3,639,607		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 5:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		
1.00	DRG Amounts Other than Outlier Payments	20,338,208	1.00
2.00	Outlier payments for discharges. (see instructions)	257,024	2.00
2.01	Outlier reconciliation amount	0	2.01
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	136.67	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment. (see instructions)	0.000000	27.00
28.00	IME Adjustment (see instructions)	0	28.00
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00
	Additional payment for high percentage of ESRD beneficiary discharges		
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0	46.00
47.00	Subtotal (see instructions)	20,595,232	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	20,595,232	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,673,919	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	10,665	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 5:13 pm
	Title XVIII	Hospital	PPS

		1.00	
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	22,279,816	59.00
60.00	Primary payer payments	1,500	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	22,278,316	61.00
62.00	Deductibles billed to program beneficiaries	2,410,888	62.00
63.00	Coinsurance billed to program beneficiaries	51,985	63.00
64.00	Allowable bad debts (see instructions)	204,434	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	143,104	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	155,355	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	19,958,547	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.93	HVBP incentive payment (see instructions)	-19,297	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)	-20,494	70.94
70.95	Recovery of Accelerated Depreciation	0	70.95
70.96	Low Volume Payment-1	0	70.96
70.97	Low Volume Payment-2	0	70.97
70.98	Low Volume Payment-3	0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	19,918,756	71.00
72.00	Interim payments	19,920,899	72.00
73.00	Tentative settlement (for contractor use only)	0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-2,143	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	75.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0	93.00
94.00	The rate used to calculate the Time Value of Money	0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)	0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0	96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	20,338,208	0	0	20,338,208	1.00
2.00	Outlier payments for discharges (see instructions)	2.00	257,024	0	0	257,024	2.00
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	20,595,232	0	0	20,595,232	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	20,595,232	0	0	20,595,232	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,673,919	0	0	1,673,919	16.00
17.00	Special add-on payments for new technologies	54.00	10,665	0	0	10,665	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	22,279,816	19.00
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,622,613	0	0	1,622,613	20.00
21.00	Capital DRG outlier payments	2.00	25,182	0	0	25,182	21.00
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0161	0.0161	0.0161	0.0161	24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	26,124	0	0	26,124	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,673,919	0	0	1,673,919	26.00
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	
27.00	Low volume adjustment factor				0.000000	0.000000	27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	29.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	20,338,208		1.00
2.00	Outlier payments for discharges (see instructions)	257,024		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
	Indirect Medical Education Adjustment			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
	Disproportionate Share Adjustment			
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	0		11.00
	Additional payment for high percentage of ESRD beneficiary discharges			
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	20,595,232		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	20,595,232		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	1,673,919		16.00
17.00	Special add-on payments for new technologies	10,665		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	22,279,816		19.00
		5.00		
20.00	Capital DRG other than outlier	1,622,613		20.00
21.00	Capital DRG outlier payments	25,182		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	26,124		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	1,673,919		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 5:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,640	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,062,651	2.00
3.00	PPS payments	8,567,390	3.00
4.00	Outlier payment (see instructions)	61,475	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.762	5.00
6.00	Line 2 times line 5	7,667,740	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)	4,640	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	21,189	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)	21,189	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 chargebasis 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)	21,189	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	16,549	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)	4,640	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)	8,628,865	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	18	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,974,915	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)	6,658,572	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)	6,658,572	30.00
31.00	Primary payer payments	189	31.00
32.00	Subtotal (line 30 minus line 31)	6,658,383	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)	249,380	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	174,566	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	165,029	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	6,832,949	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)	6,832,949	40.00
41.00	Interim payments	6,835,538	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)	-2,589	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 5:13 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	219	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	219	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,000	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)	1,000	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 chargebasis 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)	1,000	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	781	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)	219	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)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	219	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)	219	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	219	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	219	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	219	40.00
41.00	Interim payments	230	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)	-11	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		19,775,585		6,657,357	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		168,016		192,747	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	09/07/2012	32,452	09/07/2012	11,276	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	08/29/2012	55,154	08/29/2012	25,842	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)		-22,702		-14,566	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)		19,920,899		6,835,538	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,143		2,589	6.02
7.00	Total Medicare program liability (see instructions)		19,918,756		6,832,949	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: 140013	Period:	Worksheet E-1
Component CCN: 145579	From 01/01/2012 To 12/31/2012	Part I Date/Time Prepared: 5/29/2013 5:13 pm
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,170,448		230	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)		1,170,448		230	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		11	6.02
7.00	Total Medicare program liability (see instructions)		1,170,448		219	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2013 5:13 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,195,426	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,195,426	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	24,978	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,170,448	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,170,448	15.00
16.00	Interim payments	1,170,448	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G | Date/Time Prepared: 5/29/2013 5:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	125,065	0	0	0	1.00
2.00	Temporary investments	1,471,323	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,720,811	0	0	0	4.00
5.00	Other receivable	2,638,684	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,442,714	0	0	0	7.00
8.00	Prepaid expenses	1,363,773	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	15,306,675	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	45,069,045	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	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	41,642,692	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)	41,642,692	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,590,373	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	6,640,213	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,230,586	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	96,942,323	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	19,203,885	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,293,810	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	4,393,866	0	0	0	43.00
44.00	Other current liabilities	5,944,285	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,835,846	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	29,365,601	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	25,711,314	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	55,076,915	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	87,912,761	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,029,562				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,029,562	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	96,942,323	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-1 | Date/Time Prepared: 5/29/2013 5:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,674,355		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,313,357				2.00
3.00	Total (sum of line 1 and line 2)		8,360,998		0		3.00
4.00	ROUNDING	668,564		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		668,564		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,029,562		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,029,562		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	ROUNDING		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			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: 140013 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2013 5:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	34,773,358		34,773,358	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,711,147		2,711,147	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)	37,484,505		37,484,505	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,217,138		7,217,138	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)	7,217,138		7,217,138	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	44,701,643		44,701,643	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,105,350	1,105,350	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OPERATING ROOM	44,533,387	60,309,640	104,843,027	27.00
27.01	LABOR & DELIVERY ROOM	2,997,563	223,583	3,221,146	27.01
27.02	ANESTHESIA	8,471,060	7,893,513	16,364,573	27.02
27.03	RADIOLOGY	7,708,869	41,806,262	49,515,131	27.03
27.04	LAB	10,616,053	22,899,725	33,515,778	27.04
27.05	RESPIRATORY THERAPY	9,161,776	4,408,904	13,570,680	27.05
27.06	PHYSICAL THERAPY	6,425,669	4,144,072	10,569,741	27.06
27.07	EEG	19,873,866	24,555,743	44,429,609	27.07
27.08	MEDICAL SUPPLIES	0	0	0	27.08
27.09	DRUGS	17,573,082	7,879,247	25,452,329	27.09
27.10	CARDIAC REHABILITATION	2,368	354,753	357,121	27.10
27.11	CLINIC	701	8,551,350	8,552,051	27.11
27.12	EMERGENCY ROOM	5,926,307	15,910,713	21,837,020	27.12
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	177,992,344	200,042,855	378,035,199	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		108,021,612		29.00
30.00	CHULD CARE REVENUE	470,220			30.00
31.00	PROVISION FOR DOUBTFUL	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)		470,220		36.00
37.00	PROPERTY TAXES	114,000			37.00
38.00	ROUNDING	103,473			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)		217,473		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		108,274,359		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet G-3 Date/Time Prepared: 5/29/2013 5:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	378,035,199	1.00
2.00	Less contractual allowances and discounts on patients' accounts	270,808,972	2.00
3.00	Net patient revenues (line 1 minus line 2)	107,226,227	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	108,274,359	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,048,132	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	LACTATION-INPATIENT	182,185	24.00
24.01	DIETARY REV IP	2,712	24.01
24.02	DIETARY REV OP	818	24.02
24.03	NET ASSETS RELEASED FROM REST	13,527	24.03
24.04		0	24.04
24.05	NURSING ADMIN	1,451	24.05
24.06	DAYCARE CENTER	470,220	24.06
24.07	ROUND	30,576	24.07
24.08	OTHER OPERATING REVENUE	4,060,680	24.08
24.09	NON OPERATING INCOME	0	24.09
24.10		0	24.10
24.11		0	24.11
24.12		0	24.12
24.13		0	24.13
24.14		0	24.14
24.15		0	24.15
24.16		0	24.16
24.17		0	24.17
25.00	Total other income (sum of lines 6-24)	4,762,169	25.00
26.00	Total (line 5 plus line 25)	3,714,037	26.00
27.00	NET PENSION COST	397,593	27.00
27.01	PROVISION FOR DOUBTFUL	5,443,997	27.01
27.02	CHARITY CARE	2,185,804	27.02
27.03		0	27.03
27.04		0	27.04
27.05		0	27.05
27.06		0	27.06
27.07		0	27.07
27.08		0	27.08
28.00	Total other expenses (sum of line 27 and subscripts)	8,027,394	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,313,357	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H | Date/Time Prepared: 5/29/2013 5:13 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	106,415	0	0	22,737	20,306	149,458	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	309,393	0	19,626	0	0	329,019	6.00
7.00	Physical Therapy	0	0	0	185,025	0	185,025	7.00
8.00	Occupational Therapy	0	0	0	25,031	0	25,031	8.00
9.00	Speech Pathology	0	0	0	2,790	0	2,790	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	18,775	18,775	12.00
13.00	Drugs	0	0	0	0	1,593	1,593	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	415,808	0	19,626	235,583	40,674	711,691	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-2,603	146,855	0	146,855			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	329,019	0	329,019			6.00
7.00	Physical Therapy	0	185,025	0	185,025			7.00
8.00	Occupational Therapy	0	25,031	0	25,031			8.00
9.00	Speech Pathology	0	2,790	0	2,790			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	18,775	0	18,775			12.00
13.00	Drugs	0	1,593	0	1,593			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-2,603	709,088	0	709,088			24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-1 Part I Date/Time Prepared: 5/29/2013 5:13 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	146,855	0	0	0	0	146,855	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	329,019	0	0	0	0	329,019	6.00
7.00	Physical Therapy	185,025	0	0	0	0	185,025	7.00
8.00	Occupational Therapy	25,031	0	0	0	0	25,031	8.00
9.00	Speech Pathology	2,790	0	0	0	0	2,790	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	18,775	0	0	0	0	18,775	12.00
13.00	Drugs	1,593	0	0	0		1,593	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	709,088	0	0	0	0	709,088	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	146,855						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	85,939	414,958					6.00
7.00	Physical Therapy	48,329	233,354					7.00
8.00	Occupational Therapy	6,538	31,569					8.00
9.00	Speech Pathology	729	3,519					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	4,904	23,679					12.00
13.00	Drugs	416	2,009					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
24.00	Total (sum of lines 1-23)		709,088					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-1 Part II | Date/Time Prepared: 5/29/2013 5:13 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-146,855	562,233	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	329,019	6.00
7.00	Physical Therapy	0	0	0	0	0	185,025	7.00
8.00	Occupational Therapy	0	0	0	0	0	25,031	8.00
9.00	Speech Pathology	0	0	0	0	0	2,790	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	18,775	12.00
13.00	Drugs	0	0	0		0	1,593	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-146,855	562,233	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		146,855	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.261200	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	5,688	8,895	92,249	106,832	17,749	1.00
2.00	Skilled Nursing Care	414,958	0	0	0	414,958	68,942	2.00
3.00	Physical Therapy	233,354	0	0	0	233,354	38,770	3.00
4.00	Occupational Therapy	31,569	0	0	0	31,569	5,245	4.00
5.00	Speech Pathology	3,519	0	0	0	3,519	585	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	23,679	0	0	0	23,679	3,934	8.00
9.00	Drugs	2,009	0	0	0	2,009	334	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	709,088	5,688	8,895	92,249	815,920	135,559	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	8,000	6,862	0	5,730	0	23,755	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	8,000	6,862	0	5,730	0	23,755	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	27,662	786	1,279	11,958	0	210,613	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	483,900	2.00
3.00	Physical Therapy	0	0	0	0	0	272,124	3.00
4.00	Occupational Therapy	0	0	0	0	0	36,814	4.00
5.00	Speech Pathology	0	0	0	0	0	4,104	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	27,613	8.00
9.00	Drugs	0	0	0	0	0	2,343	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	27,662	786	1,279	11,958	0	1,037,511	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	210,613					1.00
2.00	Skilled Nursing Care	0	483,900	123,250	607,150			2.00
3.00	Physical Therapy	0	272,124	69,311	341,435			3.00
4.00	Occupational Therapy	0	36,814	9,377	46,191			4.00
5.00	Speech Pathology	0	4,104	1,045	5,149			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	27,613	7,033	34,646			8.00
9.00	Drugs	0	2,343	597	2,940			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,037,511	210,613	1,037,511			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.254703				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2013 5:13 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	760	760	415,808	0	106,832	760	1.00
2.00	Skilled Nursing Care	0	0	0	0	414,958	0	2.00
3.00	Physical Therapy	0	0	0	0	233,354	0	3.00
4.00	Occupational Therapy	0	0	0	0	31,569	0	4.00
5.00	Speech Pathology	0	0	0	0	3,519	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	23,679	0	8.00
9.00	Drugs	0	0	0	0	2,009	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	760	760	415,808		815,920	760	20.00
21.00	Total cost to be allocated	5,688	8,895	92,249		135,559	8,000	21.00
22.00	Unit cost multiplier	7.484211	11.703947	0.221855		0.166143	10.526316	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	760	0	760	0	415,808	415,808	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	760	0	760	0	415,808	415,808	20.00
21.00	Total cost to be allocated	6,862	0	5,730	0	23,755	27,662	21.00
22.00	Unit cost multiplier	9.028947	0.000000	7.539474	0.000000	0.057130	0.066526	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2013 5:13 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	18,775	1,593	1,105,350	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	18,775	1,593	1,105,350	0			20.00
21.00	Total cost to be allocated	786	1,279	11,958	0			21.00
22.00	Unit cost multiplier	0.041864	0.802888	0.010818	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2013 5:13 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	607,150		607,150	2,492	243.64	1.00
2.00	Physical Therapy	3.00	341,435	0	341,435	2,321	147.11	2.00
3.00	Occupational Therapy	4.00	46,191	0	46,191	314	147.11	3.00
4.00	Speech Pathology	5.00	5,149	0	5,149	35	147.11	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		999,925	0	999,925	5,162		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	1,008	236			8.00
8.01	Skilled Nursing Care		99914	1	0			8.01
8.02	Skilled Nursing Care		99916	0	0			8.02
9.00	Physical Therapy		37900	971	264			9.00
9.01	Physical Therapy		99914	4	0			9.01
9.02	Physical Therapy		99916	7	0			9.02
10.00	Occupational Therapy		37900	110	39			10.00
10.01	Occupational Therapy		99914	0	0			10.01
10.02	Occupational Therapy		99916	0	0			10.02
11.00	Speech Pathology		37900	14	6			11.00
11.01	Speech Pathology		99914	0	0			11.01
11.02	Speech Pathology		99916	0	0			11.02
12.00	Medical Social Services		37900	1	1			12.00
12.01	Medical Social Services		99914	0	0			12.01
12.02	Medical Social Services		99916	0	0			12.02
13.00	Home Health Aide		37900	0	0			13.00
13.01	Home Health Aide		99914	0	0			13.01
13.02	Home Health Aide		99916	0	0			13.02
14.00	Total (sum of lines 8-13)			2,116	546			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	34,646	0	34,646	20,189	1.716083	15.00
16.00	Cost of Drugs	9.00	2,940	0	2,940	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,009	236		245,833	57,499		1.00
2.00	Physical Therapy	982	264		144,462	38,837		2.00
3.00	Occupational Therapy	110	39		16,182	5,737		3.00
4.00	Speech Pathology	14	6		2,060	883		4.00
5.00	Medical Social Services	1	1		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	2,116	546		408,537	102,956		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	303,332						1.00
2.00	Physical Therapy	183,299						2.00
3.00	Occupational Therapy	21,919						3.00
4.00	Speech Pathology	2,943						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	511,493						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013
HHA CCN: 147049

Period:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.271046	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.464515	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.219003	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2013 5:13 pm

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			Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
	Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)		0	0	0	1.00
2.00	Total charges		0	0	0	2.00
	Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	0	3.00
4.00	Amount 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(b)		0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)		0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)		0	0	0	8.00
9.00	Primary payer amounts		0	0	0	9.00

			Part A Services	Part B Services	
			1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		399,574	111,224	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		1,637	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		13,585	7,559	13.00
14.00	Total PPS Reimbursement - PEP Episodes		4,315	2,045	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		259	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		419,370	120,828	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		419,370	120,828	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		419,370	120,828	26.00
27.00	Reimbursable bad debts (from your records)		0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140013
HHA CCN: 147049

Period:
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		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	419,370	120,828	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	419,370	120,828	31.00
32.00	Interim payments (see instructions)	419,371	120,827	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	-1	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-5 | Date/Time Prepared: 5/29/2013 5:13 pm

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			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			419,371		120,827	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				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				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. H-4, Part II, column as appropriate, line 32)			419,371		120,827	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				0		0	5.01
5.02				0		0	5.02
5.03				0		0	5.03
	Provider to Program						
5.50				0		0	5.50
5.51				0		0	5.51
5.52				0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER			0		1	6.01
6.02	SETTLEMENT TO PROGRAM			1		0	6.02
7.00	Total Medicare program liability (see instructions)			419,370		120,828	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140013 HHA CCN: 147049	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/29/2013 5:13 pm
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				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140013	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/29/2013 5:13 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,622,613	1.00
2.00	Capital DRG outlier payments	25,182	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	68.21	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.67	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	4.20	8.00
9.00	Sum of lines 7 and 8	7.87	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.61	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	26,124	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	1,673,919	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00