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: 141327

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/24/2013 2:48 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2013 Time: 2:48 pm
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 WABASH GENERAL HOSPITAL (141327) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	-17,333	-430,883	27,931	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	-102,131	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		345		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	-119,464	-430,538	27,931	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2013 1:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	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	WABASH GENERAL HOSPITAL	141327	14999	1	06/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	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: 1.00	To: 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	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.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	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 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 1:57 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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	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)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	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: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 1:57 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: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2013 1:57 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)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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.	Y		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 1:57 pm

							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.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						31,013	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: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2013 1:57 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	C	05/15/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/18/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2013 1:57 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2013 1:57 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)	04/18/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2013 1:57 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	21	7,686	66,792.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	66,792.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	39,894.00	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						13.00
14.00	Total (see instructions)		25	9,150	106,686.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,944	175	2,783			1.00
2.00	HMO	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	386	0	386			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		23	23			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,330	198	3,192			7.00
8.00	INTENSIVE CARE UNIT	64	0	109			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)	2,394	198	3,301	0.00	204.74	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	265	0	4,903	0.00	2.29	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2013 1:57 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	207.03	27.00
28.00	Observation Bed Days		0	559			28.00
29.00	Ambulance Trips	772					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	490	49	692	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	490	49	692	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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 RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2013 1:57 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	295,425	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	2,067,893	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)	0	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)	0	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	119,558	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	812,390	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	15,292	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,310,558	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-8 Date/Time Prepared: 5/24/2013 1:57 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1418 COLLEGE DRIVE	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	MT.CARMEL	IL	62863	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	12:00	21:00	18:00	21:00	18:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141327 Component CCN: 148501

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

Worksheet S-8 Date/Time Prepared: 5/24/2013 1:57 pm

Rural Health Clinic (RHC) I | Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	18:00	21:00	12:00	21:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-10 | Date/Time Prepared: 5/24/2013 1:57 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)	0.413470	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,117,387	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	116,183	5.00
6.00	Medicaid charges	7,472,170	6.00
7.00	Medicaid cost (line 1 times line 6)	3,089,518	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)	1,855,948	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)	1,855,948	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	522,233	0	522,233	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	215,928	0	215,928	21.00
22.00	Partial payment by patients approved for charity care	0	4,090	4,090	22.00
23.00	Cost of charity care (line 21 minus line 22)	215,928	-4,090	211,838	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)	4,174,173	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	426,297	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,747,876	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,549,634	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,761,472	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,617,420	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/24/2013 1:57 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		592,122	592,122	0	592,122	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		732,120	732,120	727,632	1,459,752	2.00
4.00	00400	EMPLOYEE BENEFITS	147,300	3,725,614	3,872,914	0	3,872,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,039,013	2,488,338	3,527,351	146,748	3,674,099	5.00
7.00	00700	OPERATION OF PLANT	163,796	733,992	897,788	30,913	928,701	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	233,762	53,253	287,015	18,065	305,080	9.00
10.00	01000	DIETARY	323,004	212,291	535,295	-357,234	178,061	10.00
11.00	01100	CAFETERIA	0	0	0	356,122	356,122	11.00
13.00	01300	NURSING ADMINISTRATION	201,794	15,999	217,793	0	217,793	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,778	54,956	369,734	0	369,734	16.00
17.00	01700	SOCIAL SERVICE	132,006	8,350	140,356	0	140,356	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	868,729	42,301	911,030	-6,567	904,463	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,188,831	361,280	1,550,111	-57,947	1,492,164	30.00
31.00	03100	INTENSIVE CARE UNIT	278,676	2,669	281,345	-2,071	279,274	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	614,443	329,121	943,564	-66,127	877,437	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	596,765	845,072	1,441,837	-85,384	1,356,453	54.00
60.00	06000	LABORATORY	631,678	649,494	1,281,172	-58,067	1,223,105	60.00
65.00	06500	RESPIRATORY THERAPY	410,542	161,606	572,148	-19,506	552,642	65.00
66.00	06600	PHYSICAL THERAPY	529,832	55,991	585,823	-1,649	584,174	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,639	2,343,146	2,448,785	-1,541,585	907,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,726,450	1,726,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	348,461	1,119,143	1,467,604	-2,374	1,465,230	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	182,830	6,192	189,022	-1,479	187,543	88.00
90.00	09000	CLINIC	158,893	166,914	325,807	-12,758	313,049	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,401,146	236,774	1,637,920	-34,552	1,603,368	90.01
90.02	09002	SURGICAL CLINIC	821,647	161,371	983,018	-40,138	942,880	90.02
90.03	09003	OP CLINIC	12,044	1,316	13,360	0	13,360	90.03
91.00	09100	EMERGENCY	1,202,725	1,277,238	2,479,963	-193,045	2,286,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	512,380	117,333	629,713	-18,320	611,393	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		427,966	427,966	-427,966	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,420,714	16,921,962	29,342,676	79,161	29,421,837	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	336,907	609,589	946,496	-79,161	867,335	192.00
200.00		TOTAL (SUM OF LINES 118-199)	12,757,621	17,531,551	30,289,172	0	30,289,172	200.00

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	592,122	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-250,026	1,209,726	2.00
4.00	00400	EMPLOYEE BENEFITS	-788,537	3,084,377	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-195,005	3,479,094	5.00
7.00	00700	OPERATION OF PLANT	0	928,701	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	305,080	9.00
10.00	01000	DIETARY	-9,459	168,602	10.00
11.00	01100	CAFETERIA	-84,854	271,268	11.00
13.00	01300	NURSING ADMINISTRATION	0	217,793	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-17,890	351,844	16.00
17.00	01700	SOCIAL SERVICE	0	140,356	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-868,729	35,734	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-237,500	1,254,664	30.00
31.00	03100	INTENSIVE CARE UNIT	0	279,274	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	877,437	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,277	1,354,176	54.00
60.00	06000	LABORATORY	-27,439	1,195,666	60.00
65.00	06500	RESPIRATORY THERAPY	-104,369	448,273	65.00
66.00	06600	PHYSICAL THERAPY	0	584,174	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,551	905,649	71.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,726,450		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-42	1,465,188		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	187,543		88.00
90.00	09000	CLINIC	-119,600	193,449		90.00
90.01	09001	ORTHOPAEDIC CLINIC	-1,076,823	526,545		90.01
90.02	09002	SURGICAL CLINIC	-651,381	291,499		90.02
90.03	09003	OP CLINIC	0	13,360		90.03
91.00	09100	EMERGENCY	-748,929	1,537,989		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	611,393		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,184,411	24,237,426		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	867,335		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-5,184,411	25,104,761		200.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/24/2013 1:57 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	242,508	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
	TOTALS		0	242,508	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	214,889	141,233	1.00
	TOTALS		214,889	141,233	
	C - IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,513	1.00
	TOTALS		0	5,513	
	D - MATERIALS MANAGEMENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	58,091	0	1.00
	TOTALS		58,091	0	
	E - INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	427,966	1.00
	TOTALS		0	427,966	
	F - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,263	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
	TOTALS		0	10,263	
	G - MED SUPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	238,206	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
	TOTALS		0	238,206	
	H - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	30,913	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	30,913	
	I - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,726,450	1.00
	TOTALS		0	1,726,450	
	J - LINEN				
1.00	HOUSEKEEPING	9.00	0	18,065	1.00
	TOTALS		0	18,065	
	L - INSURANCE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	57,158	1.00
	TOTALS		0	57,158	
	M - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	147,880	1.00
	TOTALS		0	147,880	
500.00	Grand Total: Increases		272,980	3,046,155	500.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/24/2013 1:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,065	9		1.00
2.00	DIETARY	10.00	0	1,112	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,053	0		3.00
4.00	OPERATING ROOM	50.00	0	20,008	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75,582	0		5.00
6.00	LABORATORY	60.00	0	23,714	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	7,528	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	725	0		8.00
9.00	ORTHOPAEDIC CLINIC	90.01	0	26,400	0		9.00
10.00	SURGICAL CLINIC	90.02	0	31,572	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	12,000	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38,749	0		12.00
	TOTALS		0	242,508			
	B - CAFETERIA						
1.00	DIETARY	10.00	214,889	141,233	0		1.00
	TOTALS		214,889	141,233			
	C - IV SOLUTIONS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,513	0		1.00
	TOTALS		0	5,513			
	D - MATERIALS MANAGEMENT						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	58,091	0	0		1.00
	TOTALS		58,091	0			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	427,966	9		1.00
	TOTALS		0	427,966			
	F - OXYGEN						
1.00	OPERATING ROOM	50.00	0	25	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	9,275	0		3.00
4.00	AMBULANCE SERVICES	95.00	0	955	0		4.00
	TOTALS		0	10,263			
	G - MED SUPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,567	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	54,894	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2,071	0		3.00
4.00	OPERATING ROOM	50.00	0	46,094	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,794	0		5.00
6.00	LABORATORY	60.00	0	34,353	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,703	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,649	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,162	0		9.00
10.00	CLINIC	90.00	0	12,758	0		10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	8,152	0		11.00
12.00	EMERGENCY	91.00	0	45,165	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	1,479	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	5,365	0		14.00
	TOTALS		0	238,206			
	H - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	8,566	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	22,347	0		2.00
	TOTALS		0	30,913			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,726,450	0		1.00
	TOTALS		0	1,726,450			
	J - LINEN						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	18,065	0		1.00
	TOTALS		0	18,065			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,158	9		1.00
	TOTALS		0	57,158			
	M - MALPRACTICE						
1.00	EMERGENCY	91.00	0	147,880	0		1.00
	TOTALS		0	147,880			
500.00	Grand Total: Decreases		272,980	3,046,155			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2013 1:57 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	416,867	0	0	0	0	1.00
2.00	Land Improvements	1,227,049	7,903	0	7,903	0	2.00
3.00	Buildings and Fixtures	16,013,255	285,394	0	285,394	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,593,072	46,428	0	46,428	0	5.00
6.00	Movable Equipment	9,846,722	342,330	0	342,330	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,096,965	682,055	0	682,055	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,096,965	682,055	0	682,055	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	416,867	0	1.00
2.00	Land Improvements	1,234,952	0	2.00
3.00	Buildings and Fixtures	16,298,649	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,639,500	0	5.00
6.00	Movable Equipment	10,189,052	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,779,020	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,779,020	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2013 1:57 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	592,122	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	732,120	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,324,242	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	592,122		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	732,120		2.00
3.00	Total (sum of lines 1-2)	0	1,324,242		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2013 1:57 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	592,122	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,209,726	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,801,848	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	592,122	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,209,726	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,801,848	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/24/2013 1:57 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)	B	-67,911	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)	B	-13,063	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-2,971,500			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	3,182			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-84,854	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,551	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-42	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-17,890	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		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	NONPHYSICIAN ANESTHETISTS	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	A	-182,115	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	DIETARY	B	-9,459	DIETARY	10.00	0	33.00
35.00	MISCELLANEOUS	B	-7,508	ADMINISTRATIVE & GENERAL	5.00	0	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/24/2013 1:57 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	
36.00	PHYSICIAN RECRUITMENT	A	-174,434	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PUBLIC RELATIONS	A	-235,196	EMPLOYEE BENEFITS	4.00	0	37.00
39.00	CRNA SALARY	A	-868,729	NONPHYSICIAN ANESTHETISTS	19.00	0	39.00
40.00	CRNA EMP BEN	A	-225,259	EMPLOYEE BENEFITS	4.00	0	40.00
42.00	EMPLOYEE DISCOUNT	A	120,036	EMPLOYEE BENEFITS	4.00	0	42.00
43.00	ORTHO EMP BEN	A	-279,217	EMPLOYEE BENEFITS	4.00	0	43.00
44.00	SURGEONS EMP BEN	A	-168,901	EMPLOYEE BENEFITS	4.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,184,411				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2013 1:57 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	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	239,291	236,109	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	239,291	236,109	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	A	DSS MRI	100.00		0.00	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:					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: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-1 Date/Time Prepared: 5/24/2013 1:57 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	3,182	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	3,182			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			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: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2013 1:57 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	237,500	237,500	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	5,459	5,459	0	0	0	2.00
3.00	60.00	LABORATORY	27,439	27,439	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	104,369	104,369	0	0	0	4.00
5.00	90.00	CLINIC	119,600	119,600	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	1,076,823	1,076,823	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	651,381	651,381	0	0	0	7.00
8.00	91.00	EMERGENCY	1,039,656	748,929	290,727	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,262,227	2,971,500	290,727		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	237,500		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,459		2.00
3.00	60.00	LABORATORY	0	0	0	27,439		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	104,369		4.00
5.00	90.00	CLINIC	0	0	0	119,600		5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	1,076,823		6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	651,381		7.00
8.00	91.00	EMERGENCY	0	0	0	748,929		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,971,500		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS: NEW BLDG & FIXT	CAPITAL RELATED COSTS: NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	592,122	592,122				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,209,726		1,209,726			2.00
4.00	00400	EMPLOYEE BENEFITS	3,084,377	1,290	2,636	3,088,303		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,479,094	38,971	79,618	338,365	3,936,048	5.00
7.00	00700	OPERATION OF PLANT	928,701	23,119	47,233	50,517	1,049,570	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	305,080	5,789	11,826	72,096	394,791	9.00
10.00	01000	DIETARY	168,602	36,775	75,133	33,345	313,855	10.00
11.00	01100	CAFETERIA	271,268	0	0	66,275	337,543	11.00
13.00	01300	NURSING ADMINISTRATION	217,793	2,778	5,675	62,237	288,483	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	351,844	10,448	21,346	97,083	480,721	16.00
17.00	01700	SOCIAL SERVICE	140,356	3,450	7,048	40,713	191,567	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	35,734	0	0	0	35,734	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,254,664	90,459	184,815	366,656	1,896,594	30.00
31.00	03100	INTENSIVE CARE UNIT	279,274	22,671	46,317	85,948	434,210	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	877,437	62,529	127,748	189,505	1,257,219	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,354,176	43,800	89,486	184,052	1,671,514	54.00
60.00	06000	LABORATORY	1,195,666	9,033	18,454	194,820	1,417,973	60.00
65.00	06500	RESPIRATORY THERAPY	448,273	9,947	20,321	126,618	605,159	65.00
66.00	06600	PHYSICAL THERAPY	584,174	61,937	126,540	163,409	936,060	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	905,649	11,882	24,275	14,665	956,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,726,450	0	0	0	1,726,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,465,188	4,534	9,263	107,471	1,586,456	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	187,543	8,979	18,344	56,388	271,254	88.00
90.00	09000	CLINIC	193,449	11,963	24,440	49,005	278,857	90.00
90.01	09001	ORTHOPAEDIC CLINIC	526,545	64,518	131,812	100,027	822,902	90.01
90.02	09002	SURGICAL CLINIC	291,499	0	0	52,513	344,012	90.02
90.03	09003	OP CLINIC	13,360	0	0	3,715	17,075	90.03
91.00	09100	EMERGENCY	1,537,989	29,418	60,103	370,945	1,998,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	611,393	31,972	65,320	158,027	866,712	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,237,426	586,262	1,197,753	2,984,395	24,115,685	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,294	4,687	0	6,981	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	867,335	3,566	7,286	103,908	982,095	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,104,761	592,122	1,209,726	3,088,303	25,104,761	202.00

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,936,048					5.00
7.00	00700	OPERATION OF PLANT	195,154	1,244,724				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	73,406	13,627	0	481,824		9.00
10.00	01000	DIETARY	58,357	86,573	0	8,228	467,013	10.00
11.00	01100	CAFETERIA	62,762	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	53,640	6,539	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,384	24,597	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	35,619	8,122	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,644	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	352,647	212,952	0	241,341	451,592	30.00
31.00	03100	INTENSIVE CARE UNIT	80,736	53,370	0	0	15,421	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	233,764	147,200	0	81,021	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,796	103,112	0	36,652	0	54.00
60.00	06000	LABORATORY	263,654	21,264	0	1,836	0	60.00
65.00	06500	RESPIRATORY THERAPY	112,521	23,415	0	4,230	0	65.00
66.00	06600	PHYSICAL THERAPY	174,048	145,808	0	31,469	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	177,843	27,972	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	321,011	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	294,981	10,674	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	50,436	21,137	0	0	0	88.00
90.00	09000	CLINIC	51,850	28,162	0	558	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	153,008	151,883	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	63,965	0	0	0	0	90.02
90.03	09003	OP CLINIC	3,175	0	0	0	0	90.03
91.00	09100	EMERGENCY	371,587	69,254	0	75,954	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	161,154	75,267	0	535	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,752,142	1,230,928	0	481,824	467,013	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,298	5,400	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	182,608	8,396	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,936,048	1,244,724	0	481,824	467,013	202.00

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	400,305					11.00
13.00	01300	NURSING ADMINISTRATION	5,420	354,082				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,704	0	617,406			16.00
17.00	01700	SOCIAL SERVICE	5,959	0	0	241,267		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,469	0	0	0	49,847	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,385	158,299	537,205	233,300	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,352	27,069	35,995	7,967	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,474	67,897	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	49,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,827	0	0	0	0	54.00
60.00	06000	LABORATORY	31,494	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,791	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20,924	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,696	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	11,136	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,175	0	0	0	0	88.00
90.00	09000	CLINIC	8,574	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	32,491	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	14,237	0	0	0	0	90.02
90.03	09003	OP CLINIC	512	0	0	0	0	90.03
91.00	09100	EMERGENCY	42,279	100,817	44,206	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	34,406	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	400,305	354,082	617,406	241,267	49,847	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	400,305	354,082	617,406	241,267	49,847	202.00

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
			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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,150,315	0	4,150,315			30.00
31.00	03100	INTENSIVE CARE UNIT	666,120	0	666,120			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,815,575	0	1,815,575			50.00
53.00	05300	ANESTHESIOLOGY	49,847	0	49,847			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,149,901	0	2,149,901			54.00
60.00	06000	LABORATORY	1,736,221	0	1,736,221			60.00
65.00	06500	RESPIRATORY THERAPY	765,116	0	765,116			65.00
66.00	06600	PHYSICAL THERAPY	1,308,309	0	1,308,309			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,164,982	0	1,164,982			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,047,461	0	2,047,461			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,903,247	0	1,903,247			73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	349,002	0	349,002			88.00
90.00	09000	CLINIC	368,001	0	368,001			90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,160,284	0	1,160,284			90.01
90.02	09002	SURGICAL CLINIC	422,214	0	422,214			90.02
90.03	09003	OP CLINIC	20,762	0	20,762			90.03
91.00	09100	EMERGENCY	2,702,552	0	2,702,552			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,138,074	0	1,138,074			95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,917,983	0	23,917,983			118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,679	0	13,679			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,173,099	0	1,173,099			192.00
200.00		Cross Foot Adjustments	0	0	0			200.00
201.00		Negative Cost Centers	0	0	0			201.00
202.00		TOTAL (sum lines 118-201)	25,104,761	0	25,104,761			202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/24/2013 1:57 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	1,290	2,636	3,926	3,926	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	38,971	79,618	118,589	430	5.00
7.00	00700	OPERATION OF PLANT	0	23,119	47,233	70,352	64	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,789	11,826	17,615	92	9.00
10.00	01000	DIETARY	0	36,775	75,133	111,908	42	10.00
11.00	01100	CAFETERIA	0	0	0	0	84	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,778	5,675	8,453	79	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,448	21,346	31,794	123	16.00
17.00	01700	SOCIAL SERVICE	0	3,450	7,048	10,498	52	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	90,459	184,815	275,274	466	30.00
31.00	03100	INTENSIVE CARE UNIT	0	22,671	46,317	68,988	109	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	62,529	127,748	190,277	241	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,800	89,486	133,286	234	54.00
60.00	06000	LABORATORY	0	9,033	18,454	27,487	248	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,947	20,321	30,268	161	65.00
66.00	06600	PHYSICAL THERAPY	0	61,937	126,540	188,477	208	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,882	24,275	36,157	19	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	4,534	9,263	13,797	137	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,979	18,344	27,323	72	88.00
90.00	09000	CLINIC	0	11,963	24,440	36,403	62	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	64,518	131,812	196,330	127	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	67	90.02
90.03	09003	OP CLINIC	0	0	0	0	5	90.03
91.00	09100	EMERGENCY	0	29,418	60,103	89,521	471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	31,972	65,320	97,292	201	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	586,262	1,197,753	1,784,015	3,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,294	4,687	6,981	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,566	7,286	10,852	132	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	592,122	1,209,726	1,801,848	3,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	119,019					5.00
7.00	00700	OPERATION OF PLANT	5,901	76,317				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	2,220	836	0	20,763		9.00
10.00	01000	DIETARY	1,764	5,308	0	355	119,377	10.00
11.00	01100	CAFETERIA	1,898	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,622	401	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,703	1,508	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,077	498	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	201	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,663	13,056	0	10,401	115,435	30.00
31.00	03100	INTENSIVE CARE UNIT	2,441	3,272	0	0	3,942	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,068	9,025	0	3,491	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,397	6,322	0	1,579	0	54.00
60.00	06000	LABORATORY	7,972	1,304	0	79	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,402	1,436	0	182	0	65.00
66.00	06600	PHYSICAL THERAPY	5,263	8,940	0	1,356	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,377	1,715	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,706	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,919	654	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,525	1,296	0	0	0	88.00
90.00	09000	CLINIC	1,568	1,727	0	24	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4,626	9,312	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1,934	0	0	0	0	90.02
90.03	09003	OP CLINIC	96	0	0	0	0	90.03
91.00	09100	EMERGENCY	11,243	4,246	0	3,273	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,873	4,615	0	23	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,459	75,471	0	20,763	119,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39	331	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,521	515	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	119,019	76,317	0	20,763	119,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,982					11.00
13.00	01300	NURSING ADMINISTRATION	27	10,582				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112	0	36,240			16.00
17.00	01700	SOCIAL SERVICE	30	0	0	12,155		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	37	0	0	0	238	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	329	4,731	31,532	11,754		30.00
31.00	03100	INTENSIVE CARE UNIT	56	809	2,113	401		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141	2,029	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138	0	0	0		54.00
60.00	06000	LABORATORY	156	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	98	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	104	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	31	0	0	0		88.00
90.00	09000	CLINIC	42	0	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	161	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	70	0	0	0		90.02
90.03	09003	OP CLINIC	3	0	0	0		90.03
91.00	09100	EMERGENCY	209	3,013	2,595	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	170	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,982	10,582	36,240	12,155	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					238	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,982	10,582	36,240	12,155	238	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	473,641	0	473,641		30.00
31.00	03100	INTENSIVE CARE UNIT	82,131	0	82,131		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	212,272	0	212,272		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,956	0	150,956		54.00
60.00	06000	LABORATORY	37,246	0	37,246		60.00
65.00	06500	RESPIRATORY THERAPY	35,547	0	35,547		65.00
66.00	06600	PHYSICAL THERAPY	204,348	0	204,348		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,281	0	43,281		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,706	0	9,706		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,562	0	23,562		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	30,247	0	30,247		88.00
90.00	09000	CLINIC	39,826	0	39,826		90.00
90.01	09001	ORTHOPAEDIC CLINIC	210,556	0	210,556		90.01
90.02	09002	SURGICAL CLINIC	2,071	0	2,071		90.02
90.03	09003	OP CLINIC	104	0	104		90.03
91.00	09100	EMERGENCY	114,571	0	114,571		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	107,174	0	107,174		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,777,239	0	1,777,239		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,351	0	7,351		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,020	0	17,020		192.00
200.00		Cross Foot Adjustments	238	0	238		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,801,848	0	1,801,848		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 1:57 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	66,079					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		66,079				2.00
4.00	00400	EMPLOYEE BENEFITS	144	144	10,013,388			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,349	4,349	1,097,103	-3,936,048	21,168,713	5.00
7.00	00700	OPERATION OF PLANT	2,580	2,580	163,796	0	1,049,570	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	646	646	233,762	0	394,791	9.00
10.00	01000	DIETARY	4,104	4,104	108,116	0	313,855	10.00
11.00	01100	CAFETERIA	0	0	214,889	0	337,543	11.00
13.00	01300	NURSING ADMINISTRATION	310	310	201,794	0	288,483	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,166	1,166	314,778	0	480,721	16.00
17.00	01700	SOCIAL SERVICE	385	385	132,006	0	191,567	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	35,734	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,095	10,095	1,188,831	0	1,896,594	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	2,530	278,676	0	434,210	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,978	6,978	614,443	0	1,257,219	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,888	4,888	596,765	0	1,671,514	54.00
60.00	06000	LABORATORY	1,008	1,008	631,678	0	1,417,973	60.00
65.00	06500	RESPIRATORY THERAPY	1,110	1,110	410,542	0	605,159	65.00
66.00	06600	PHYSICAL THERAPY	6,912	6,912	529,832	0	936,060	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	1,326	47,548	0	956,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,726,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506	506	348,461	0	1,586,456	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,002	1,002	182,830	0	271,254	88.00
90.00	09000	CLINIC	1,335	1,335	158,893	0	278,857	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	7,200	324,323	0	822,902	90.01
90.02	09002	SURGICAL CLINIC	0	0	170,266	0	344,012	90.02
90.03	09003	OP CLINIC	0	0	12,044	0	17,075	90.03
91.00	09100	EMERGENCY	3,283	3,283	1,202,725	0	1,998,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	3,568	512,380	0	866,712	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,425	65,425	9,676,481	-3,936,048	20,179,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	256	0	0	6,981	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398	398	336,907	0	982,095	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	592,122	1,209,726	3,088,303		3,936,048	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.960820	18.307269	0.308417		0.185937	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,926		119,019	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000392		0.005622	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (POUNDS)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	59,006					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,731				8.00
9.00	00900	HOUSEKEEPING	646	0	20,731			9.00
10.00	01000	DIETARY	4,104	354	354	9,903		10.00
11.00	01100	CAFETERIA	0	0	0	0	14,846	11.00
13.00	01300	NURSING ADMINISTRATION	310	0	0	0	201	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,166	0	0	0	842	16.00
17.00	01700	SOCIAL SERVICE	385	0	0	0	221	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	277	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,095	10,384	10,384	9,576	2,462	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	0	0	327	421	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,978	3,486	3,486	0	1,056	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,888	1,577	1,577	0	1,032	54.00
60.00	06000	LABORATORY	1,008	79	79	0	1,168	60.00
65.00	06500	RESPIRATORY THERAPY	1,110	182	182	0	734	65.00
66.00	06600	PHYSICAL THERAPY	6,912	1,354	1,354	0	776	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	0	0	0	100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506	0	0	0	413	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,002	0	0	0	229	88.00
90.00	09000	CLINIC	1,335	24	24	0	318	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	0	0	0	1,205	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	528	90.02
90.03	09003	OP CLINIC	0	0	0	0	19	90.03
91.00	09100	EMERGENCY	3,283	3,268	3,268	0	1,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	23	23	0	1,276	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,352	20,731	20,731	9,903	14,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,244,724	0	481,824	467,013	400,305	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.094872	0.000000	23.241715	47.158740	26.963829	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,317	0	20,763	119,377	1,982	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.293377	0.000000	1.001544	12.054630	0.133504	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 1:57 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,507					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,000				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,301			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,462	8,701	3,192			30.00
31.00	03100	INTENSIVE CARE UNIT	421	583	109			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,056	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	1,568	716	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,507	10,000	3,301	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	354,082	617,406	241,267	49,847		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	64.296713	61.740600	73.089064	498.470000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,582	36,240	12,155	238		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.921554	3.624000	3.682218	2.380000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 1:57 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	4,150,315		4,150,315	0	0	3,235,759	30.00
31.00	03100	INTENSIVE CARE UNIT	666,120		666,120	0	0	142,812	31.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,815,575		1,815,575	0	0	3,600,100	50.00
53.00	05300	ANESTHESIOLOGY	49,847		49,847	0	0	737,166	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,149,901		2,149,901	0	0	675,831	54.00
60.00	06000	LABORATORY	1,736,221		1,736,221	0	0	1,095,195	60.00
65.00	06500	RESPIRATORY THERAPY	765,116	0	765,116	0	0	382,543	65.00
66.00	06600	PHYSICAL THERAPY	1,308,309	0	1,308,309	0	0	376,483	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,164,982		1,164,982	0	0	1,223,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,047,461		2,047,461	0	0	3,306,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,903,247		1,903,247	0	0	1,710,470	73.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	349,002		349,002	0	0	0	88.00
90.00	09000	CLINIC	368,001		368,001	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,160,284		1,160,284	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	422,214		422,214	0	0	0	90.02
90.03	09003	OP CLINIC	20,762		20,762	0	0	0	90.03
91.00	09100	EMERGENCY	2,702,552		2,702,552	0	0	67,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	622,016		622,016		0	10,675	92.00
		OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,138,074		1,138,074	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	24,539,999	0	24,539,999	0	0	16,564,976	200.00
201.00		Less Observation Beds	622,016		622,016		0		201.00
202.00		Total (see instructions)	23,917,983	0	23,917,983	0	0	16,564,976	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		3,235,759					30.00
31.00	03100	INTENSIVE CARE UNIT		142,812					31.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,213,793	8,813,893	0.205990	0.000000	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	1,157,765	1,894,931	0.026305	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,632,746	11,308,577	0.190112	0.000000	0.000000		54.00
60.00	06000	LABORATORY	8,676,196	9,771,391	0.177684	0.000000	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	1,302,198	1,684,741	0.454145	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,468,350	1,844,833	0.709175	0.000000	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,069,732	2,293,469	0.507956	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	348,837	3,655,454	0.560111	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,456,043	5,166,513	0.368381	0.000000	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	411,104	411,104					88.00
90.00	09000	CLINIC	414,306	414,306	0.888235	0.000000	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	263,637	263,637	4.401067	0.000000	0.000000		90.01
90.02	09002	SURGICAL CLINIC	51,525	51,525	8.194352	0.000000	0.000000		90.02
90.03	09003	OP CLINIC	79,636	79,636	0.260711	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	4,746,411	4,813,999	0.561394	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	428,579	439,254	1.416074	0.000000	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,561,062	1,561,062	0.729038	0.000000	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	41,281,920	57,846,896					200.00
201.00		Less Observation Beds							201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

	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		
202.00	Total (see instructions)	41,281,920	57,846,896					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

		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	4,150,315		4,150,315	0	0	3,235,759	30.00
31.00	03100	INTENSIVE CARE UNIT	666,120		666,120	0	0	142,812	31.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,815,575		1,815,575	0	0	3,600,100	50.00
53.00	05300	ANESTHESIOLOGY	49,847		49,847	0	0	737,166	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,149,901		2,149,901	0	0	675,831	54.00
60.00	06000	LABORATORY	1,736,221		1,736,221	0	0	1,095,195	60.00
65.00	06500	RESPIRATORY THERAPY	765,116	0	765,116	0	0	382,543	65.00
66.00	06600	PHYSICAL THERAPY	1,308,309	0	1,308,309	0	0	376,483	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,164,982		1,164,982	0	0	1,223,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,047,461		2,047,461	0	0	3,306,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,903,247		1,903,247	0	0	1,710,470	73.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	349,002		349,002	0	0	0	88.00
90.00	09000	CLINIC	368,001		368,001	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,160,284		1,160,284	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	422,214		422,214	0	0	0	90.02
90.03	09003	OP CLINIC	20,762		20,762	0	0	0	90.03
91.00	09100	EMERGENCY	2,702,552		2,702,552	0	0	67,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	622,016		622,016		0	10,675	92.00
		OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,138,074		1,138,074	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	24,539,999	0	24,539,999	0	0	16,564,976	200.00
201.00		Less Observation Beds	622,016		622,016		0		201.00
202.00		Total (see instructions)	23,917,983	0	23,917,983	0	0	16,564,976	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		3,235,759					30.00
31.00	03100	INTENSIVE CARE UNIT		142,812					31.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,213,793	8,813,893	0.205990	0.000000	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	1,157,765	1,894,931	0.026305	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,632,746	11,308,577	0.190112	0.000000	0.000000		54.00
60.00	06000	LABORATORY	8,676,196	9,771,391	0.177684	0.000000	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	1,302,198	1,684,741	0.454145	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,468,350	1,844,833	0.709175	0.000000	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,069,732	2,293,469	0.507956	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	348,837	3,655,454	0.560111	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,456,043	5,166,513	0.368381	0.000000	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	411,104	411,104	0.848938	0.000000	0.000000		88.00
90.00	09000	CLINIC	414,306	414,306	0.888235	0.000000	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	263,637	263,637	4.401067	0.000000	0.000000		90.01
90.02	09002	SURGICAL CLINIC	51,525	51,525	8.194352	0.000000	0.000000		90.02
90.03	09003	OP CLINIC	79,636	79,636	0.260711	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	4,746,411	4,813,999	0.561394	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	428,579	439,254	1.416074	0.000000	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,561,062	1,561,062	0.729038	0.000000	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	41,281,920	57,846,896					200.00
201.00		Less Observation Beds							201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/24/2013 1:57 pm
	Title XIX	Hospital	

	Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
		Outpatient	Total (col. 6 + col. 7)					
		7.00	8.00	9.00	10.00	11.00		
202.00	Total (see instructions)	41,281,920	57,846,896					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		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	212,272	8,813,893	0.024084	2,104,662	50,689	50.00
53.00	05300	ANESTHESIOLOGY	0	1,894,931	0.000000	455,888	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,956	11,308,577	0.013349	415,111	5,541	54.00
60.00	06000	LABORATORY	37,246	9,771,391	0.003812	787,411	3,002	60.00
65.00	06500	RESPIRATORY THERAPY	35,547	1,684,741	0.021099	303,463	6,403	65.00
66.00	06600	PHYSICAL THERAPY	204,348	1,844,833	0.110768	217,986	24,146	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,281	2,293,469	0.018871	782,339	14,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,706	3,655,454	0.002655	2,081,895	5,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,562	5,166,513	0.004561	1,082,603	4,938	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	30,247	411,104	0.073575	0	0	88.00
90.00	09000	CLINIC	39,826	414,306	0.096127	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	210,556	263,637	0.798659	0	0	90.01
90.02	09002	SURGICAL CLINIC	2,071	51,525	0.040194	0	0	90.02
90.03	09003	OP CLINIC	104	79,636	0.001306	0	0	90.03
91.00	09100	EMERGENCY	114,571	4,813,999	0.023800	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	439,254	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,114,293	52,907,263		8,231,358	115,010	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		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
53.00	05300	ANESTHESIOLOGY	49,847	0	0	0	49,847	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	49,847	0	0	0	49,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		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	8,813,893	0.000000	0.000000	2,104,662	50.00
53.00	05300	ANESTHESIOLOGY	0	1,894,931	0.026305	0.000000	455,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,308,577	0.000000	0.000000	415,111	54.00
60.00	06000	LABORATORY	0	9,771,391	0.000000	0.000000	787,411	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,684,741	0.000000	0.000000	303,463	65.00
66.00	06600	PHYSICAL THERAPY	0	1,844,833	0.000000	0.000000	217,986	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,293,469	0.000000	0.000000	782,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,655,454	0.000000	0.000000	2,081,895	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,166,513	0.000000	0.000000	1,082,603	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	411,104	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	414,306	0.000000	0.000000	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	263,637	0.000000	0.000000	0	90.01
90.02	09002	SURGICAL CLINIC	0	51,525	0.000000	0.000000	0	90.02
90.03	09003	OP CLINIC	0	79,636	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,813,999	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	439,254	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	52,907,263			8,231,358	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	11,992	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	11,992	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		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	0.205990	0	1,525,499	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026305	0	345,616	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190112	0	4,162,085	0	0	54.00
60.00	06000	LABORATORY	0.177684	0	4,376,533	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.454145	0	570,110	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.709175	0	547,290	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507956	0	366,953	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.560111	0	105,791	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368381	0	2,104,075	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.888235	0	15,533	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.401067	0	76,795	0	0	90.01
90.02	09002	SURGICAL CLINIC	8.194352	0	19,285	0	0	90.02
90.03	09003	OP CLINIC	0.260711	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.561394	0	1,445,410	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.416074	0	393,163	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.729038		0			95.00
200.00		Subtotal (see instructions)		0	16,054,138	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,054,138	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		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	314,238	0		50.00
53.00	05300	ANESTHESIOLOGY	9,091	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,262	0		54.00
60.00	06000	LABORATORY	777,640	0		60.00
65.00	06500	RESPIRATORY THERAPY	258,913	0		65.00
66.00	06600	PHYSICAL THERAPY	388,124	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	186,396	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	59,255	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	775,101	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	13,797	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	337,980	0		90.01
90.02	09002	SURGICAL CLINIC	158,028	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	811,445	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	556,748	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,438,018	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,438,018	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		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	0.205990	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026305	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190112	0	0	0	0	54.00
60.00	06000	LABORATORY	0.177684	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.454145	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.709175	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507956	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.560111	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368381	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.888235	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.401067	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	8.194352	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.260711	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.561394	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.416074	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.729038		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		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
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

		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	0.205990	0	0	745,500	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026305	0	0	350,354	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190112	0	0	1,756,149	0	54.00
60.00	06000	LABORATORY	0.177684	0	0	981,045	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.454145	0	0	187,052	0	65.00
66.00	06600	PHYSICAL THERAPY	0.709175	0	0	128,592	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507956	0	0	228,656	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.560111	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368381	0	0	502,952	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.848938				0	88.00
90.00	09000	CLINIC	0.888235	0	0	96,232	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.401067	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	8.194352	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.260711	0	0	17,076	0	90.03
91.00	09100	EMERGENCY	0.561394	0	0	1,177,168	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.416074	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.729038	0	0			95.00
200.00		Subtotal (see instructions)		0	0	6,170,776	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	6,170,776	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

		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	153,566		50.00
53.00	05300	ANESTHESIOLOGY	0	9,216		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	333,865		54.00
60.00	06000	LABORATORY	0	174,316		60.00
65.00	06500	RESPIRATORY THERAPY	0	84,949		65.00
66.00	06600	PHYSICAL THERAPY	0	91,194		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	116,147		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	185,278		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	85,477		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	4,452		90.03
91.00	09100	EMERGENCY	0	660,855		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,899,315		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,899,315		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

	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)	3,751	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,342	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,783	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	386	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	23	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,944	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)	386	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,150,315	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)	2,071	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)	431,585	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,718,730	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,675,013	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,675,013	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.011896	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)	1,320.52	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)	3,718,730	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,112.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,163,147	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)	2,163,147	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	666,120	109	6,111.19	64	391,116	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)	2,919,061	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,473,324	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	429,514	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)	429,514	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)	559	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,112.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	622,016	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

	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)	3,751	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,342	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,783	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	386	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	23	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)	175	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	23	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,150,315	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)	2,071	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)	431,585	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,718,730	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,675,013	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,675,013	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.011896	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)	1,320.52	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)	3,718,730	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,112.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	194,728	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)	194,728	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

	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	666,120	109	6,111.19	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	194,728	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	194,728	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)	2,071	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)	2,071	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)	559	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,112.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	622,016	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

	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	3,718,730	0.000000	622,016	0	90.00
91.00	Nursing School cost	0	3,718,730	0.000000	622,016	0	91.00
92.00	Allied health cost	0	3,718,730	0.000000	622,016	0	92.00
93.00	All other Medical Education	0	3,718,730	0.000000	622,016	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,074,898		30.00
31.00	03100	INTENSIVE CARE UNIT		109,897		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.205990	2,104,662	433,539	50.00
53.00	05300	ANESTHESIOLOGY	0.026305	455,888	11,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190112	415,111	78,918	54.00
60.00	06000	LABORATORY	0.177684	787,411	139,910	60.00
65.00	06500	RESPIRATORY THERAPY	0.454145	303,463	137,816	65.00
66.00	06600	PHYSICAL THERAPY	0.709175	217,986	154,590	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507956	782,339	397,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.560111	2,081,895	1,166,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368381	1,082,603	398,810	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.888235	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.401067	0	0	90.01
90.02	09002	SURGICAL CLINIC	8.194352	0	0	90.02
90.03	09003	OP CLINIC	0.260711	0	0	90.03
91.00	09100	EMERGENCY	0.561394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.416074	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		8,231,358	2,919,061	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)		8,231,358		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.205990	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026305	1,627	43	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190112	26,539	5,045	54.00
60.00	06000	LABORATORY	0.177684	59,740	10,615	60.00
65.00	06500	RESPIRATORY THERAPY	0.454145	43,413	19,716	65.00
66.00	06600	PHYSICAL THERAPY	0.709175	66,410	47,096	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507956	64,593	32,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.560111	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368381	222,696	82,037	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.888235	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4.401067	0	0	90.01
90.02	09002	SURGICAL CLINIC	8.194352	0	0	90.02
90.03	09003	OP CLINIC	0.260711	0	0	90.03
91.00	09100	EMERGENCY	0.561394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.416074	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		485,018	197,362	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)		485,018		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/24/2013 1:57 pm

Title XIX | Hospital

		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		211,583		30.00
31.00	03100	INTENSIVE CARE UNIT		8,729		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	197,079	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	113,837	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	33,240	0	54.00
60.00	06000	LABORATORY	0.000000	61,243	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	22,384	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	13,544	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	312,080	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	108,956	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.000000	3,371	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		865,734	0	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)		865,734		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 1:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,438,018	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,438,018	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,492,398	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)	52,505	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,324,385	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)	3,115,508	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)	3,115,508	30.00
31.00	Primary payer payments	2,943	31.00
32.00	Subtotal (line 30 minus line 31)	3,112,565	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)	381,405	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	381,405	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)	3,493,970	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)	3,493,970	40.00
41.00	Interim payments	3,924,853	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)	-430,883	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2013 1:57 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,584,150		3,771,380	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/24/2012	499,893	08/24/2012	171,840	3.01
3.02		11/01/2012	86,979	11/01/2012	43,934	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	08/24/2012	2,391	08/24/2012	62,301	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)		584,481		153,473	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)		5,168,631		3,924,853	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		17,333		430,883	6.02
7.00	Total Medicare program liability (see instructions)		5,151,298		3,493,970	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: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2013 1:57 pm

Component CCN: 14Z327 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		686,224		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/24/2012	33,332		0	3.01
3.02		11/01/2012	11,240		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)		44,572		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)		730,796		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		102,131		0	6.02
7.00	Total Medicare program liability (see instructions)		628,665		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/24/2013 1:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	692	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,008	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,892	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	57,846,896	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	522,233	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	31,013	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	27,931	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	27,931	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141327 Component CCN: 14Z327	Period: From 01/01/2012 To 12/31/2012	Worksheet E-2 Date/Time Prepared: 5/24/2013 1:57 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	433,809	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	199,336	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	386	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	633,145	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	633,145	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	633,145	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,480	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	628,665	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	628,665	0	19.00
20.00	Interim payments	730,796	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-102,131	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/24/2013 1:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	5,473,324	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,473,324	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,528,057	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,528,057	19.00
20.00	Deductibles (exclude professional component)	403,444	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,124,613	22.00
23.00	Coinsurance	18,207	23.00
24.00	Subtotal (line 22 minus line 23)	5,106,406	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	44,892	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	44,892	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,151,298	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	5,151,298	30.00
31.00	Interim payments	5,168,631	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	-17,333	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G | Date/Time Prepared: 5/24/2013 1:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,501,505	0	0	0	1.00
2.00	Temporary investments	5,344,018	0	0	0	2.00
3.00	Notes receivable	69,363	0	0	0	3.00
4.00	Accounts receivable	12,972,297	0	0	0	4.00
5.00	Other receivable	83,782	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,657,752	0	0	0	6.00
7.00	Inventory	557,848	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	440,382	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,311,443	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	31,779,020	0	0	0	15.00
16.00	Accumulated depreciation	-18,344,921	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)	13,434,099	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	611,184	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	611,184	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,356,726	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	700,016	0	0	0	37.00
38.00	Salaries, wages, and fees payable	911,688	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	62,946	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	0	0	0	0	43.00
44.00	Other current liabilities	2,412,956	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,087,606	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,850,049	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,850,049	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,937,655	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,419,071				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)	17,419,071	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,356,726	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-1 | Date/Time Prepared: 5/24/2013 1:57 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		14,354,841		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,509,988				2.00
3.00	Total (sum of line 1 and line 2)		16,864,829		0		3.00
4.00	Additions (credit adjustments) (specify)	554,242		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)		554,242		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,419,071		0		11.00
12.00	Deductions (debit adjustments) (specify)	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)		17,419,071		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2013 1:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,675,013		3,675,013	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,675,013		3,675,013	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	142,812		142,812	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)	142,812		142,812	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,817,825		3,817,825	17.00
18.00	Ancillary services	13,843,301	39,256,666	53,099,967	18.00
19.00	Outpatient services	0	598,637	598,637	19.00
20.00	RURAL HEALTH CLINIC	0	411,104	411,104	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,561,062	1,561,062	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	32,785	9,422,906	9,455,691	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,693,911	51,250,375	68,944,286	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,289,172		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON-OPERATING EXPENSES	3,567,433			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		3,567,433		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,721,739		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141327	Period: From 01/01/2012 To 12/31/2012	Worksheet G-3 Date/Time Prepared: 5/24/2013 1:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	68,944,286	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,405,540	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,538,746	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,721,739	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,817,007	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,090,487	24.00
24.01	NON-OPERATING DEDUCTIONS	2,888,650	24.01
25.00	Total other income (sum of lines 6-24)	4,979,137	25.00
26.00	Total (line 5 plus line 25)	8,796,144	26.00
27.00	NON-OPERATING G/L	584,017	27.00
27.01	NON-OPERATING REVENUE	5,702,139	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	6,286,156	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,509,988	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2012 To 12/31/2012 | Worksheet M-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	102,385	0	102,385	0	102,385	2.00
3.00	Nurse Practitioner	12,971	0	12,971	0	12,971	3.00
4.00	Visiting Nurse	574	0	574	0	574	4.00
5.00	Other Nurse	66,900	0	66,900	0	66,900	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	182,830	0	182,830	0	182,830	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	2,780	2,780	-1,479	1,301	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	2,780	2,780	-1,479	1,301	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	182,830	2,780	185,610	-1,479	184,131	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	3,412	3,412	0	3,412	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	3,412	3,412	0	3,412	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	182,830	6,192	189,022	-1,479	187,543	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2012 To 12/31/2012 | Worksheet M-1 | Date/Time Prepared: 5/24/2013 1:57 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	102,385		2.00
3.00	Nurse Practitioner	0	12,971		3.00
4.00	Visiting Nurse	0	574		4.00
5.00	Other Nurse	0	66,900		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	182,830		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	1,301		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	1,301		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	184,131		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	3,412		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	3,412		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	187,543		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141327 | Period: From 01/01/2012 To 12/31/2012 | Worksheet M-2

Component CCN: 148501 | Date/Time Prepared: 5/24/2013 1:57 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	14	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.01	4,889	2,100	2,121		3.00
4.00	Subtotal (sum of lines 1-3)	1.02	4,903		2,163	4,903	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.02	4,903			4,903	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					184,131	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					184,131	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					3,412	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					161,459	15.00
16.00	Total overhead (sum of lines 14 and 15)					164,871	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					164,871	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					164,871	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					349,002	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141327 Component CCN: 148501	Period: From 01/01/2012 To 12/31/2012	Worksheet M-3 Date/Time Prepared: 5/24/2013 1:57 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		349,002	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		349,002	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,903	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,903	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		71.18	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	71.18	71.18	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	265	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	18,863	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		18,863	16.00
16.01	Total program charges (see instructions)(from contractor's records)		24,504	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		12,182	16.04
16.05	Total program cost (see instructions)		12,182	16.05
17.00	Primary payer amounts		94	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,635	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		12,088	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		12,088	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		12,088	26.00
27.00	Interim payments		11,743	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		345	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141327 Component CCN: 148501	Period: From 01/01/2012 To 12/31/2012	Worksheet M-5 Date/Time Prepared: 5/24/2013 1:57 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		11,513	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	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		08/24/2012	230	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		230	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		11,743	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	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		345	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		12,088	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00