

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 10:05 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2013	Time: 10:05 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARSHA BEHAVIORAL CENTER (154054) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	6,474	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	6,474	0	0	0	200.00

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

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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/29/2013 Time: 10:05 am

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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 HARSHA BEHAVIORAL CENTER (154054) 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.

Encryption Information
 ECR: Date: 5/29/2013 Time: 10:05 am
 EMfw: RCeKi 7fx1szXT9mUWwj apk7LO
 2pFFE0VVeD0vhHLB.cONEONVFRmP6p
 gcKd0316yw0V0tNY
 PI: Date: 5/29/2013 Time: 10:05 am
 .uLXgNuEF8pVuvPWCPourqX10Fe0.0
 E7yv00bYJhFHI wuSTI S271nZI 7m3y
 UDTn04xVFE07ov3I

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	6,474	0	0	1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	4.00
5.00	Swing bed - SNF	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	12.00
200.00	Total	0	6,474	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 154054		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 9:50 am			
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47802 County: VIGO			
1.00 Street: 1420 EAST CROSSING BLVD		2.00 State: IN		3.00 Zip Code: 47802		4.00 County: VIGO			
2.00 City: TERRE HAUTE		3.00 State: IN		4.00 Zip Code: 47802		5.00 County: VIGO			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
				1.00	2.00	3.00	4.00	5.00	6.00 7.00 8.00
				1.00	2.00	3.00	4.00	5.00	6.00 7.00 8.00
3.00	Hospital and Hospital-Based Component Identification:								
	Hospital	HARSHA BEHAVIORAL CENTER	154054	45460	4	09/30/2009	N	P	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)						4		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.						3	N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 9:50 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	30,182	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		N		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 154054		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 9:50 am		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 9:50 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N		Legal Oper.	
		1.00		2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		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	N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 9:50 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			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.			N	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.	HOLLY		NEAR	41.00
42.00	Enter the employer/company name of the cost report preparer.	HARSHA BEHAVIORAL CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 231-5222		HNEAR@HARSHACENTER.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		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.	CHIEF ADMINISTRATIVE OFFICER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 5/29/2013 9:50 am
		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 154054

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2013 9:50 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	44	16,104	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		44	16,104	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		44	16,104	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		44				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 Vi s i t s / Tri ps			Full Time Equivalents		
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	3,355	7,165	12,171			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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,355	7,165	12,171			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)	3,355	7,165	12,171	0.00	96.18	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part I Date/Time Prepared: 5/29/2013 9:50 am
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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	96.18	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			
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)							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							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	290	905	1,356	14.00
15.00	CAH visits										15.00
16.00	SUBPROVIDER - IPF										16.00
17.00	SUBPROVIDER - IRF										17.00
18.00	SUBPROVIDER										18.00
19.00	SKILLED NURSING FACILITY										19.00
20.00	NURSING FACILITY										20.00
21.00	OTHER LONG TERM CARE										21.00
22.00	HOME HEALTH AGENCY										22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)										23.00
24.00	HOSPICE										24.00
25.00	CMHC - CMHC										25.00
26.00	RURAL HEALTH CLINIC										26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER										26.25
27.00	Total (sum of lines 14-26)					0.00					27.00
28.00	Observation Bed Days										28.00
29.00	Ambulance Trips										29.00
30.00	Employee discount days (see instruction)										30.00
31.00	Employee discount days - IRF										31.00
32.00	Labor & delivery days (see instructions)										32.00
33.00	LTCH non-covered days										33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 154054

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

Worksheet A
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		421,311	421,311	0	421,311	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		29,367	29,367	0	29,367	2.00
4.00	00400	EMPLOYEE BENEFITS	0	457,359	457,359	0	457,359	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	485,701	485,701	538,497	1,024,198	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	113,688	113,688	32,651	146,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	160,438	160,438	0	160,438	8.00
9.00	00900	HOUSEKEEPING	0	28,468	28,468	48,265	76,733	9.00
10.00	01000	DIETARY	189,516	219,396	408,912	0	408,912	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	75,879	75,879	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	33,223	33,223	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,156,189	346,244	3,502,433	-814,988	2,687,445	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	33,784	33,784	0	33,784	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,312	36,312	0	36,312	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	156,007	156,007	0	156,007	73.00
76.00	03020	GROUP THERAPY	0	4,193	4,193	74,995	79,188	76.00
76.01	03021	INDIVIDUAL THERAPY	0	0	0	13,972	13,972	76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		2,494	2,494	-2,494	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,345,705	2,494,762	5,840,467	0	5,840,467	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	3,345,705	2,494,762	5,840,467	0	5,840,467	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	-16,620	404,691				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	29,367				2.00
4.00	00400	EMPLOYEE BENEFITS	0	457,359				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-89,945	934,253				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	0	146,339				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	160,438				8.00
9.00	00900	HOUSEKEEPING	0	76,733				9.00
10.00	01000	DIETARY	-23,822	385,090				10.00
11.00	01100	CAFETERIA	0	0				11.00
13.00	01300	NURSING ADMINISTRATION	0	75,879				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,223				16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,687,445				30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	33,784				60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,312				71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	156,007				73.00
76.00	03020	GROUP THERAPY	0	79,188				76.00
76.01	03021	INDIVIDUAL THERAPY	0	13,972				76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-130,387	5,710,080				118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	NON-REIMBURSABLE MEALS	0	0				194.00
200.00		TOTAL (SUM OF LINES 118-199)	-130,387	5,710,080				200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 154054

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

Worksheet Non-CMS W
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	06000		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	GROUP THERAPY	03020		76.00
76.01	INDIVIDUAL THERAPY	03021		76.01
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
194.00	NON-REIMBURSABLE MEALS	07950		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	536,003	0	1.00
2.00	OPERATION OF PLANT	7.00	32,651	0	2.00
3.00	HOUSEKEEPING	9.00	48,265	0	3.00
4.00	NURSING ADMINISTRATION	13.00	75,879	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	33,223	0	5.00
	TOTALS		726,021	0	
B - THERAPY SALARIES					
1.00	GROUP THERAPY	76.00	74,995	0	1.00
2.00	INDIVIDUAL THERAPY	76.01	13,972	0	2.00
	TOTALS		88,967	0	
C - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,494	1.00
	TOTALS		0	2,494	
500.00	Grand Total: Increases		814,988	2,494	500.00

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	726,021	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		726,021	0		
B - THERAPY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	88,967	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		88,967	0		
C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	2,494	0	1.00
	TOTALS		0	2,494		
500.00	Grand Total: Decreases		814,988	2,494		500.00

RECLASSIFICATIONS

Provider CCN: 154054

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/29/2013 9:50 am

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	536,003	ADULTS & PEDIATRICS	30.00	726,021
2.00	OPERATION OF PLANT	7.00	32,651		0.00	0
3.00	HOUSEKEEPING	9.00	48,265		0.00	0
4.00	NURSING ADMINISTRATION	13.00	75,879		0.00	0
5.00	MEDICAL RECORDS & LIBRARY	16.00	33,223		0.00	0
	TOTALS		726,021	TOTALS		726,021
B - THERAPY SALARIES						
1.00	GROUP THERAPY	76.00	74,995	ADULTS & PEDIATRICS	30.00	88,967
2.00	INDIVIDUAL THERAPY	76.01	13,972		0.00	0
	TOTALS		88,967	TOTALS		88,967
C - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	INTEREST EXPENSE	113.00	0
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		814,988	Grand Total: Decreases		814,988

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 154054

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2013 9:50 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	45,643	8,600	0	8,600	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	266,619	123,756	0	123,756	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	312,262	132,356	0	132,356	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	312,262	132,356	0	132,356	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	54,243	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	390,375	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	444,618	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	444,618	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 154054

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	59,158	362,153	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	27,280	0	2,087	0	2.00
3.00	Total (sum of lines 1-2)	59,158	389,433	0	2,087	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	421,311				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	29,367				2.00
3.00	Total (sum of lines 1-2)	0	450,678				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 154054

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	54,243	0	54,243	0.121999	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	390,375	0	390,375	0.878001	0	2.00
3.00	Total (sum of lines 1-2)	444,618	0	444,618	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	59,158	345,533	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	27,280	2.00
3.00	Total (sum of lines 1-2)	0	0	0	59,158	372,813	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	404,691	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,087	0	0	29,367	2.00
3.00	Total (sum of lines 1-2)	0	2,087	0	0	434,058	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-16,620	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	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		0		0.00	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-23,822	0	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-336	0	ADMINISTRATIVE & GENERAL	5.00	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	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MARKETING-NON SALARY	A	-45,474	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 MARKETING-SALARY AND BENEFITS	A	-31,196	0	ADMINISTRATIVE & GENERAL	5.00	0	33.01

Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8 Date/Time Prepared: 5/29/2013 9:50 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
33.02 CHARITABLE CONTRIBUTIONS	A	-12,939	ADMINISTRATIVE & GENERAL	5.00	0	33.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-130,387				50.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 154054

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	404,691	404,691			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	29,367		29,367		2.00
4.00 00400	EMPLOYEE BENEFITS	457,359	0	0	457,359	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	934,253	83,531	6,062	73,272	1,097,118
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	146,339	0	0	4,463	150,802
8.00 00800	LAUNDRY & LINEN SERVICE	160,438	0	0	0	160,438
9.00 00900	HOUSEKEEPING	76,733	0	0	6,598	83,331
10.00 01000	DIETARY	385,090	42,021	3,049	25,907	456,067
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	75,879	0	0	10,373	86,252
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	33,223	0	0	4,542	37,765
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,687,445	221,981	16,108	320,042	3,245,576
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	33,784	0	0	0	33,784
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,312	0	0	0	36,312
73.00 07300	DRUGS CHARGED TO PATIENTS	156,007	0	0	0	156,007
76.00 03020	GROUP THERAPY	79,188	55,923	4,058	10,252	149,421
76.01 03021	INDIVIDUAL THERAPY	13,972	1,235	90	1,910	17,207
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,710,080	404,691	29,367	457,359	5,710,080
NONREIMBURSABLE COST CENTERS						
194.00 07950	NON-REIMBURSABLE MEALS	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	5,710,080	404,691	29,367	457,359	5,710,080
GENERAL SERVICE COST CENTERS						
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
		5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,097,118				5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00 00700	OPERATION OF PLANT	35,866	0	186,668		7.00
8.00 00800	LAUNDRY & LINEN SERVICE	38,158	0	0	198,596	8.00
9.00 00900	HOUSEKEEPING	19,819	0	0	0	103,150
10.00 01000	DIETARY	108,468	0	24,424	0	13,496
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	20,514	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	8,982	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	771,907	0	129,022	198,596	71,296
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	8,035	0	0	0	60.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,636	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	37,104	0	0	0	73.00
76.00 03020	GROUP THERAPY	35,537	0	32,504	0	17,961
76.01 03021	INDIVIDUAL THERAPY	4,092	0	718	0	397
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,097,118	0	186,668	198,596	103,150
NONREIMBURSABLE COST CENTERS						
194.00 07950	NON-REIMBURSABLE MEALS	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	1,097,118	0	186,668	198,596	103,150

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 154054

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

Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	602,455					10.00
11.00	01100	CAFETERIA	170,588	170,588				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,799	111,565			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,789	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	420,133	158,258	111,565	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	0	4,039	0	0	0	76.00
76.01	03021	INDIVIDUAL THERAPY	0	703	0	0	0	76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	590,721	170,588	111,565	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	NON-REIMBURSABLE MEALS	11,734	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	602,455	170,588	111,565	0	0	202.00
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,536					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,129	0	5,151,482	0	5,151,482	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	181	0	42,000	0	42,000	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25	0	44,973	0	44,973	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,231	0	194,342	0	194,342	73.00
76.00	03020	GROUP THERAPY	2,486	0	241,948	0	241,948	76.00
76.01	03021	INDIVIDUAL THERAPY	484	0	23,601	0	23,601	76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,536	0	5,698,346	0	5,698,346	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	NON-REIMBURSABLE MEALS	0	0	11,734	0	11,734	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	49,536	0	5,710,080	0	5,710,080	202.00

COST ALLOCATION STATISTICS

Provider CCN: 154054

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

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Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS	SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-100	ACCUM.	COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE	FEET	6.00
7.00	OPERATION OF PLANT	3	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	99	PATIENT	DAYS	8.00
9.00	HOUSEKEEPING	3	SQUARE	FEET	9.00
10.00	DIETARY	98	MEALS	SERVED	10.00
11.00	CAFETERIA	11	HOURS	WORKED	11.00
13.00	NURSING ADMINISTRATION	99	PATIENT	DAYS	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	14.00
15.00	PHARMACY	15	COSTED	REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME	SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	83,531	6,062	89,593	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	42,021	3,049	45,070	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	221,981	16,108	238,089	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	60.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	GROUP THERAPY	0	55,923	4,058	59,981	76.00
76.01 03021	INDIVIDUAL THERAPY	0	1,235	90	1,325	76.01
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	404,691	29,367	434,058	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	NON-REIMBURSABLE MEALS	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	404,691	29,367	434,058	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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From 01/01/2012
To 12/31/2012

Worksheet B
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Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	89,593				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	2,929	0	2,929		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,116	0	0	3,116	8.00
9.00	00900	HOUSEKEEPING	1,618	0	0	0	9.00
10.00	01000	DIETARY	8,858	0	383	0	212
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,675	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	733	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	63,037	0	2,025	3,116	1,118
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	656	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	705	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,030	0	0	0	0
76.00	03020	GROUP THERAPY	2,902	0	510	0	282
76.01	03021	INDIVIDUAL THERAPY	334	0	11	0	6
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,593	0	2,929	3,116	1,618
NONREIMBURSABLE COST CENTERS							
194.00	07950	NON-REIMBURSABLE MEALS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	89,593	0	2,929	3,116	1,618

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

Period:
From 01/01/2012
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	54,523					10.00
11.00	01100	15,438	15,438				11.00
13.00	01300	0	434	2,109			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	252	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	38,023	14,323	2,109	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	365	0	0	0	76.00
76.01	03021	0	64	0	0	0	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		53,461	15,438	2,109	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	1,062	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		54,523	15,438	2,109	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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

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Part II
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	985				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	896	0	362,736	0	362,736
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	4	0	660	0	660
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	705	0	705
73.00	07300	DRUGS CHARGED TO PATIENTS	25	0	3,055	0	3,055
76.00	03020	GROUP THERAPY	50	0	64,090	0	64,090
76.01	03021	INDIVIDUAL THERAPY	10	0	1,750	0	1,750
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	985	0	432,996	0	432,996
NONREIMBURSABLE COST CENTERS							
194.00	07950	NON-REIMBURSABLE MEALS	0	0	1,062	0	1,062
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	985	0	434,058	0	434,058

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	24,568					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		24,568				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	3,345,705			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,071	5,071	536,003	-1,097,118	4,612,962	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	0	32,651	0	150,802	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	160,438	8.00
9.00 00900	HOUSEKEEPING	0	0	48,265	0	83,331	9.00
10.00 01000	DIETARY	2,551	2,551	189,516	0	456,067	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	75,879	0	86,252	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	33,223	0	37,765	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	13,476	13,476	2,341,201	0	3,245,576	30.00
ANCILLARY SERVICE COST CENTERS							
60.00 06000	LABORATORY	0	0	0	0	33,784	60.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	36,312	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	156,007	73.00
76.00 03020	GROUP THERAPY	3,395	3,395	74,995	0	149,421	76.00
76.01 03021	INDIVIDUAL THERAPY	75	75	13,972	0	17,207	76.01
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,568	24,568	3,345,705	-1,097,118	4,612,962	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	404,691	29,367	457,359		1,097,118	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.472281	1.195335	0.136700		0.237834	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		89,593	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019422	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	19,497			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	12,171		8.00
9.00	00900	HOUSEKEEPING	0	0	0	19,497	9.00
10.00	01000	DIETARY	0	2,551	0	2,551	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	13,476	12,171	13,476	35,805
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	0	3,395	0	3,395	76.00
76.01	03021	INDIVIDUAL THERAPY	0	75	0	75	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	19,497	12,171	19,497	50,343
NONREIMBURSABLE COST CENTERS							
194.00	07950	NON-REIMBURSABLE MEALS	0	0	0	0	1,000
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)	0	186,668	198,596	103,150	602,455
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	9.574191	16.317147	5.290558	11.733927
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,929	3,116	1,618	54,523
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.150228	0.256018	0.082987	1.061936

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	147,880					11.00
13.00	01300	4,160	12,171				13.00
14.00	01400	0	0	0			14.00
15.00	01500	0	0	0	0		15.00
16.00	01600	2,418	0	0	0	13,015,326	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	137,192	12,171	0	0	11,857,455	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	47,427	60.00
71.00	07100	0	0	0	0	6,534	71.00
73.00	07300	0	0	0	0	323,475	73.00
76.00	03020	3,501	0	0	0	653,310	76.00
76.01	03021	609	0	0	0	127,125	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		147,880	12,171	0	0	13,015,326	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		170,588	111,565	0	0	49,536	202.00
203.00		1.153557	9.166461	0.000000	0.000000	0.003806	203.00
204.00		15,438	2,109	0	0	985	204.00
205.00		0.104395	0.173281	0.000000	0.000000	0.000076	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	GROUP THERAPY	76.00
76.01	03021	INDIVIDUAL THERAPY	76.01
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	NON-REIMBURSABLE MEALS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 154054

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2013 9:50 am

			Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Disallowance	Total Costs	Inpatient		
			1.00	2.00	3.00	4.00	5.00	6.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	5,151,482		5,151,482	0	5,151,482	11,857,455	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000 LABORATORY	42,000		42,000	0	42,000	47,427	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44,973		44,973	0	44,973	6,534	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	194,342		194,342	0	194,342	323,475	73.00
76.00	03020 GROUP THERAPY	241,948		241,948	0	241,948	653,310	76.00
76.01	03021 INDIVIDUAL THERAPY	23,601		23,601	0	23,601	127,125	76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE							113.00
200.00	Subtotal (see instructions)	5,698,346	0	5,698,346	0	5,698,346	13,015,326	200.00
201.00	Less Observation Beds	0		0		0		201.00
202.00	Total (see instructions)	5,698,346	0	5,698,346	0	5,698,346	13,015,326	202.00
Charges								
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
	7.00	8.00					9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS		11,857,455					30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000 LABORATORY	0	47,427	0.885572	0.000000	0.885572		60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,534	6.882920	0.000000	6.882920		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	323,475	0.600794	0.000000	0.600794		73.00
76.00	03020 GROUP THERAPY	0	653,310	0.370342	0.000000	0.370342		76.00
76.01	03021 INDIVIDUAL THERAPY	0	127,125	0.185652	0.000000	0.185652		76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE							113.00
200.00	Subtotal (see instructions)	0	13,015,326					200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	0	13,015,326					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/29/2013 9:50 am
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges		
			Total Costs	RCE Disallowance	Total Costs	Inpatient		
			1.00	2.00	3.00	4.00	5.00	6.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS	5,151,482		5,151,482	0	0	11,857,455	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000 LABORATORY	42,000		42,000	0	0	47,427	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44,973		44,973	0	0	6,534	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	194,342		194,342	0	0	323,475	73.00
76.00	03020 GROUP THERAPY	241,948		241,948	0	0	653,310	76.00
76.01	03021 INDIVIDUAL THERAPY	23,601		23,601	0	0	127,125	76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE							113.00
200.00	Subtotal (see instructions)	5,698,346	0	5,698,346	0	0	13,015,326	200.00
201.00	Less Observation Beds	0		0		0		201.00
202.00	Total (see instructions)	5,698,346	0	5,698,346	0	0	13,015,326	202.00
Charges								
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
	7.00	8.00						9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS		11,857,455					30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000 LABORATORY	0	47,427	0.885572	0.000000	0.000000		60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,534	6.882920	0.000000	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	323,475	0.600794	0.000000	0.000000		73.00
76.00	03020 GROUP THERAPY	0	653,310	0.370342	0.000000	0.000000		76.00
76.01	03021 INDIVIDUAL THERAPY	0	127,125	0.185652	0.000000	0.000000		76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE							113.00
200.00	Subtotal (see instructions)	0	13,015,326					200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)	0	13,015,326					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 154054		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/29/2013 9:50 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	362,736	0	362,736	12,171	29.80	30.00
200.00	Total (Lines 30-199)	362,736		362,736	12,171		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,355	99,979				
200.00	Total (Lines 30-199)	3,355	99,979				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 154054		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/29/2013 9:50 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			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								
60.00	06000	LABORATORY	660	47,427	0.013916	46,719	650	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	705	6,534	0.107897	6,232	672	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,055	323,475	0.009444	318,250	3,006	73.00
76.00	03020	GROUP THERAPY	64,090	653,310	0.098100	639,450	62,730	76.00
76.01	03021	INDIVIDUAL THERAPY	1,750	127,125	0.013766	123,300	1,697	76.01
200.00		Total (lines 50-199)	70,260	1,157,871		1,133,951	68,755	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 154054		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/29/2013 9:50 am	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,171	0.00	3,355	0	30.00
200.00		Total (lines 30-199)	12,171		3,355	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			
200.00		Total (lines 30-199)	0	0			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 9:50 am
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Cost Center Description	Title XVIII				Hospital		PPS
	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							
60.00	06000	LABORATORY	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	0	0	0	0	76.00
76.01	03021	INDIVIDUAL THERAPY	0	0	0	0	76.01
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 9:50 am
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Cost Center Description	Title XVIII			Hospital		PPS		
	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								
60.00	06000	LABORATORY	0	47,427	0.000000	0.000000	46,719	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,534	0.000000	0.000000	6,232	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	323,475	0.000000	0.000000	318,250	73.00
76.00	03020	GROUP THERAPY	0	653,310	0.000000	0.000000	639,450	76.00
76.01	03021	INDIVIDUAL THERAPY	0	127,125	0.000000	0.000000	123,300	76.01
200.00		Total (lines 50-199)	0	1,157,871			1,133,951	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 154054

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	0	0	0	0	76.00
76.01	03021	INDIVIDUAL THERAPY	0	0	0	0	76.01
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 9:50 am
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	GROUP THERAPY	0	0		76.00
76.01	03021	INDIVIDUAL THERAPY	0	0		76.01
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2013 9:50 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,171	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,171	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)		12,171	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,355	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,151,482	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,151,482	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		11,857,455	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		11,857,455	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.434451	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)		974.24	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,151,482	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)		423.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,420,037	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,420,037	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 9:50 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					535,176 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,955,213 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)					99,979 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					68,755 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					168,734 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,786,479 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 9:50 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	362,736	5,151,482	0.070414	0	0	90.00
91.00	Nursing School cost	0	5,151,482	0.000000	0	0	91.00
92.00	Allied health cost	0	5,151,482	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,151,482	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2013 9:50 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,171	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,171	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)		12,171	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,165	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,151,482	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,151,482	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		11,857,455	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		11,857,455	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.434451	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)		974.24	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,151,482	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)		423.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,032,658	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)		3,032,658	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 9:50 am
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,032,658 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 154054

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

Worksheet D-1
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 9:50 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,378,485		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.885572	46,719	41,373	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6.882920	6,232	42,894	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.600794	318,250	191,203	73.00
76.00	03020 GROUP THERAPY	0.370342	639,450	236,815	76.00
76.01	03021 INDIVIDUAL THERAPY	0.185652	123,300	22,891	76.01
200.00	Total (sum of lines 50-94 and 96-98)		1,133,951	535,176	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,133,951		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 9:50 am	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,073,180		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.885572	0	0	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6.882920	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.600794	0	0	73.00
76.00	03020 GROUP THERAPY	0.370342	0	0	76.00
76.01	03021 INDIVIDUAL THERAPY	0.185652	0	0	76.01
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		0	0	202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 154054

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2013 9:50 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,390,001		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,390,001		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		6,474		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,396,475		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		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/29/2013 9:50 am
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,605,210 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			33.254098 9.00
10.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,605,210 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,605,210 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,605,210 18.00
19.00	Deductibles			172,148 19.00
20.00	Subtotal (line 18 minus line 19)			2,433,062 20.00
21.00	Coinsurance			43,061 21.00
22.00	Subtotal (line 20 minus line 21)			2,390,001 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			9,248 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			6,474 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			9,248 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,396,475 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,396,475 31.00
32.00	Interim payments			2,390,001 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			6,474 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 154054	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 9:50 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,032,658		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,032,658	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,032,658	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,073,180		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		7,073,180	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		7,073,180	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,040,522	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,032,658	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,032,658	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,032,658	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,032,658	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,032,658	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,032,658	0	40.00
41.00	Interim payments		3,032,658	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 154054

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

Worksheet G

Date/Time Prepared:
5/29/2013 9:50 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	100	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,096,193	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	413	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)	2,096,706	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	54,243	0	0	0	17.00
18.00	Accumulated depreciation	-27,058	0	0	0	18.00
19.00	Fixed equipment	168,178	0	0	0	19.00
20.00	Accumulated depreciation	-22,965	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	222,197	0	0	0	23.00
24.00	Accumulated depreciation	-115,396	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)	279,199	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	121,410	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	121,410	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,497,315	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	91,572	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,254	0	0	0	38.00
39.00	Payroll taxes payable	18,551	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	117,622	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	229,999	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	229,999	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,267,316				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)	2,267,316	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,497,315	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 154054

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

Worksheet G-1

Date/Time Prepared:
5/29/2013 9:50 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		1,318,502		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,919,095			2.00
3.00	Total (sum of line 1 and line 2)		3,237,597		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		3,237,597		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	OWNERS/PERSONAL EST TAXES DRAW	951,304		0		13.00
14.00	ADJUSTMENT TO BALANCE	330		0		14.00
15.00	RESTATEMENT OF BEGINNING BALANCE	18,647		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		970,281		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,267,316		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	OWNERS/PERSONAL EST TAXES DRAW		0			13.00
14.00	ADJUSTMENT TO BALANCE		0			14.00
15.00	RESTATEMENT OF BEGINNING BALANCE		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: 154054

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2013 9:50 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,857,455		11,857,455	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)	11,857,455		11,857,455	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,857,455		11,857,455	17.00
18.00	Ancillary services	1,185,271	0	1,185,271	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,042,726	0	13,042,726	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		5,840,467		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		5,840,467		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 154054

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

Worksheet G-3

Date/Time Prepared:
5/29/2013 9:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	13,042,726	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,325,581	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,717,145	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	5,840,467	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,876,678	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	23,822	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	336	21.00
22.00	Rental of hospital space	16,620	22.00
23.00	Governmental appropriations	1,639	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	42,417	25.00
26.00	Total (line 5 plus line 25)	1,919,095	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,919,095	29.00