

**PART I - COST REPORT STATUS** Date: 5/30/2013 Time: 9:50 am

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.

**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 CENTERPOINTE HOSPITAL ( 264012 ) 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) *J. Mall*  
 Officer or Administrator of Provider(s)  
 Title *CFO*  
 Date *05/30/2013*

**Encryption Information**  
 ECR: Date: 5/30/2013 Time: 9:50 am  
 2phV62bNXQmrzb1XYEcXPTLSboXvt0  
 f9Yo40rtDBD8:j8AQhMIinz5h8goX5  
 T6so00UDP:0aUH69  
 PI: Date: 5/30/2013 Time: 9:50 am  
 BEKs4JezGOLTino7CQqj2Y01hc.J60  
 xqNy00.lSbnOMEZmZYBeouwJpjqqa90  
 N:RL0g.fab0qzQn2

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	63,322	-38,022	0	1,193,653	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	63,322	-38,022	0	1,193,653	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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(signed) *J. Maed*  
 Officer or Administrator of Provider(s)  
 Title CEO  
 Date 05/30/2013

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	63,322	-38,022	0	1,193,653	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	63,322	-38,022	0	1,193,653	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.

	1.00	2.00	3.00	4.00								
<b>Hospital and Hospital Health Care Complex Address:</b>												1.00
1.00	Street: 4801 WELDON SPRINGS PARKWAY	PO Box:	Zip Code: 63304	County: ST. CHARLES								2.00
2.00	City: ST. CHARLES	State: MO										
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)						
						V	XVIII	XIX				
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00				
<b>Hospital and Hospital-Based Component Identification:</b>												
3.00	Hospital	CENTERPOINTE HOSPITAL	264012	41180	4	12/31/1980	N	P	D			3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
6.01	Subprovider - (Other) II											6.01
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012					20.00
21.00	Type of Control (see instructions)						4					21.00
	<b>Inpatient PPS Information</b>											
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.					Y	N					22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,634	0	2,040	0	1,619	0					24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0					25.00
						Urban/Rural S	Date of Geogr					
						1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1					26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1					27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0					35.00

		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0			37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N				39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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	Y		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
<b>Teaching Hospitals</b>						
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.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
<b>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.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (See instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 5:01 pm		
		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
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
<b>Inpatient Rehabilitation Facility PPS</b>						
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	
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N			Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N			N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00			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
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					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
<b>Miscellaneous Cost Reporting Information</b>						
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.	1				118.00

		Premiums	Losses	Insurance																																																																					
		1.00	2.00	3.00																																																																					
118.01	List amounts of malpractice premiums and paid losses:	38,400	0		118.01																																																																				
		1.00	2.00																																																																						
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02																																																																				
119.00	DO NOT USE THIS LINE				119.00																																																																				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00																																																																				
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00																																																																				
<b>Transplant Center Information</b>																																																																									
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																																																																				
<b>All Providers</b>																																																																									
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:		Zip Code:																																																																					
143.00	City:	State:																																																																							
				1.00																																																																					
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00																																																																				
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00																																																																				
		1.00	2.00																																																																						
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00																																																																				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00																																																																				
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00																																																																				
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00																																																																				
<table border="1"> <thead> <tr> <th></th> <th>Part A</th> <th>Part B</th> <th>Title V</th> <th>Title XIX</th> <th></th> </tr> <tr> <th></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th></th> </tr> </thead> <tbody> <tr> <td>155.00</td> <td>Hospital</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>155.00</td> </tr> <tr> <td>156.00</td> <td>Subprovider - IPF</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>156.00</td> </tr> <tr> <td>157.00</td> <td>Subprovider - IRF</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>157.00</td> </tr> <tr> <td>158.00</td> <td>SUBPROVIDER</td> <td></td> <td></td> <td></td> <td></td> <td>158.00</td> </tr> <tr> <td>158.01</td> <td>CHEMICAL DEPENDENCY</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>158.01</td> </tr> <tr> <td>159.00</td> <td>SNF</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>159.00</td> </tr> <tr> <td>160.00</td> <td>HOME HEALTH AGENCY</td> <td>N</td> <td>N</td> <td>N</td> <td>N</td> <td>160.00</td> </tr> <tr> <td>161.00</td> <td>CMHC</td> <td></td> <td>N</td> <td>N</td> <td>N</td> <td>161.00</td> </tr> </tbody> </table>							Part A	Part B	Title V	Title XIX			1.00	2.00	3.00	4.00		155.00	Hospital	N	N	N	N	155.00	156.00	Subprovider - IPF	N	N	N	N	156.00	157.00	Subprovider - IRF	N	N	N	N	157.00	158.00	SUBPROVIDER					158.00	158.01	CHEMICAL DEPENDENCY	N	N	N	N	158.01	159.00	SNF	N	N	N	N	159.00	160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	161.00	CMHC		N	N	N	161.00
	Part A	Part B	Title V	Title XIX																																																																					
	1.00	2.00	3.00	4.00																																																																					
155.00	Hospital	N	N	N	N	155.00																																																																			
156.00	Subprovider - IPF	N	N	N	N	156.00																																																																			
157.00	Subprovider - IRF	N	N	N	N	157.00																																																																			
158.00	SUBPROVIDER					158.00																																																																			
158.01	CHEMICAL DEPENDENCY	N	N	N	N	158.01																																																																			
159.00	SNF	N	N	N	N	159.00																																																																			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00																																																																			
161.00	CMHC		N	N	N	161.00																																																																			

							1.00	
<b>Multicampus</b>								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
							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	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
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)							0168.00
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: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 5:01 pm
		Y/N 1.00	Date 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.				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
<b>Financial Data and Reports</b>				
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 1.00	Legal Oper. 2.00	
<b>Approved Educational Activities</b>				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
		Y/N 1.00		
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
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
<b>PS&amp;R Data</b>				
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	05/13/2013	Y
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
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
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
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

	Description	Part A		Part B		
		Y/N	Date	Y/N		
	0	1.00	2.00	3.00		21.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		
				1.00		
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
<b>Interest Expense</b>						
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
<b>Home Office Costs</b>						
36.00	were home office costs claimed on the cost report?		N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
<b>Cost Report Preparer Contact Information</b>						
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.	RONALD		MOORE		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTERPOINTE HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	RMOORE@CPHMO.NET		314-441-7300		43.00

		Part B	
		Date	
		4.00	
16.00	<p><b>PS&amp;R Data</b></p> <p>was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4 .(see instructions)</p>	05/13/2013	16.00
17.00	<p>was the cost report prepared using the PS&amp;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)</p>		17.00
18.00	<p>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions.</p>		18.00
19.00	<p>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for corrections of other PS&amp;R Report information? If yes, see instructions.</p>		19.00
20.00	<p>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for Other? Describe the other adjustments:</p>		20.00
21.00	<p>Was the cost report prepared only using the provider's records? If yes, see instructions.</p>		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	<p>Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</p>	REIMBURSEMENT SPECIALIST	41.00
42.00	<p>Enter the employer/company name of the cost report preparer.</p>		42.00
43.00	<p>Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.</p>		43.00

		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
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 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
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 1.00	Title XIX 2.00	
<b>RCE DISALLOWANCE</b>				
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
<b>PASS THROUGH COST</b>				
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

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title v
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	104	38,064	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)		104	38,064	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)		104	38,064	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	42.00	0	0		0	18.00
18.01 CHEMICAL DEPENDENCY	42.01	32	11,712		0	18.01
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)		136			0	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

Cost Center Description	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	6,741	5,674	28,185			1.00
2.00 HMO	0	1,619				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)	6,741	5,674	28,185			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)	6,741	5,674	28,185	0.00	302.00	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	0	0	0	0.00	0.00	18.00
18.01 CHEMICAL DEPENDENCY	0	0	4,644	0.00	19.00	18.01
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	0	0.00	321.00	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					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)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

Cost Center Description	Discharges					Total All Patients	
	Full Time Equivalents	Title v	Title XVIII	Title XIX	15.00		
	Nonpaid Workers	12.00	13.00	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	518	503	3,802	1.00	
2.00 HMO			48			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	518	503	3,802	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00	
18.01 CHEMICAL DEPENDENCY	0.00	0	0	0	358	18.01	
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: 264012

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

Worksheet A

Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		93,745	93,745	1,900,289	1,994,034	1.00
2.00	00200		555,540	555,540	56,657	612,197	2.00
3.00	00300		303,009	303,009	-303,009	0	3.00
4.00	00400	177,401	3,726,551	3,903,952	7,224	3,911,176	4.00
5.00	00500	3,348,092	3,337,567	6,685,659	-842,904	5,842,755	5.00
6.00	00600	205,070	570,103	775,173	-5,664	769,509	6.00
8.00	00800	0	80,836	80,836	0	80,836	8.00
9.00	00900	0	348,829	348,829	0	348,829	9.00
10.00	01000	309,762	832,162	1,141,924	-425	1,141,499	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01301	784,203	36,746	820,949	-529	820,420	13.00
16.00	01600	367,628	235,643	603,271	-11,620	591,651	16.00
17.00	01700	557,241	4,122	561,363	-30	561,333	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	6,784,303	1,868,814	8,653,117	-109,537	8,543,580	30.00
42.00	04200	0	0	0	0	0	42.00
42.01	04201	999,797	373,574	1,373,371	27,053	1,400,424	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	0	0	0	0	0	57.00
70.00	07000	116,077	88,086	204,163	27,360	231,523	70.00
73.00	07300	51,022	853,872	904,894	-15	904,879	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	3,431,676	2,914,723	6,346,399	-782,232	5,564,167	90.00
90.01	09001	0	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		50,738	50,738	-50,738	0	113.00
118.00		17,132,272	16,274,660	33,406,932	-88,120	33,318,812	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	88,120	88,120	190.01
193.00	19301	0	0	0	0	0	193.00
200.00		17,132,272	16,274,660	33,406,932	0	33,406,932	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 264012

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

Worksheet A

Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	0	1,994,034	1.00
2.00	00200	-15,431	596,766	2.00
3.00	00300	0	0	3.00
4.00	00400	-20,480	3,890,696	4.00
5.00	00500	-1,805,695	4,037,060	5.00
6.00	00600	-7,051	762,458	6.00
8.00	00800	0	80,836	8.00
9.00	00900	0	348,829	9.00
10.00	01000	0	1,141,499	10.00
11.00	01100	-65,161	-65,161	11.00
13.00	01301	0	820,420	13.00
16.00	01600	-686	590,965	16.00
17.00	01700	0	561,333	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	-1,113,443	7,430,137	30.00
42.00	04200	0	0	42.00
42.01	04201	-251,893	1,148,531	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>				
57.00	05701	0	0	57.00
70.00	07000	0	231,523	70.00
73.00	07300	0	904,879	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	-740,480	4,823,687	90.00
90.01	09001	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	0	0	113.00
118.00		-4,020,320	29,298,492	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
190.01	19001	0	88,120	190.01
193.00	19301	0	0	193.00
200.00		-4,020,320	29,386,612	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>B - TO RECLASS POSTAGE &amp; TELEPHONE</b>					
1.00		0.00	0	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	107	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	0	36,272	10.00
TOTALS			0	36,379	
<b>C - TO RECLASS SHORT &amp; LONG TERM LEASES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,900,289	1.00
2.00	EMPLOYEE BENEFITS	4.00	0	1,482	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
TOTALS			0	1,901,771	
<b>D - TO RECLASS LAB COSTS TO CD</b>					
1.00	CHEMICAL DEPENDENCY	42.01	0	20,993	1.00
TOTALS			0	20,993	
<b>E - TO RECLASS COMMUNITY RELATIONS EXP</b>					
1.00	COMMUNITY RELATIONS	190.01	53,450	34,670	1.00
TOTALS			53,450	34,670	
<b>F - TO RECLASS PROPERTY TAX</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	303,009	1.00
2.00		0.00	0	0	2.00
TOTALS			0	303,009	
<b>G - TO RECLASS ECT COSTS</b>					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	27,360	1.00
TOTALS			0	27,360	
<b>H - TO RECLASSIFY INTERST EXPENSE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,738	1.00
TOTALS			0	50,738	
<b>J - TO RECLASS DRIVERS TO ADMIN</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	5,848	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	27,830	0	2.00
TOTALS			27,830	5,848	
<b>K - TO RECLASS RADIOLOGY COSTS TO CD</b>					
1.00	CHEMICAL DEPENDENCY	42.01	0	6,060	1.00
TOTALS			0	6,060	
<b>L - TO RECLASS DRIVERS ADMIN TIME</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	316,753	1.00
TOTALS			0	316,753	
<b>M - RECLASS DEPRECIATION EXPENSE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	56,657	1.00
TOTALS			0	56,657	
500.00	Grand Total: Increases		81,280	2,760,238	500.00

		Decreases				wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>B - TO RECLASS POSTAGE &amp; TELEPHONE</b>							
1.00	EMPLOYEE BENEFITS	4.00	0	106	0		1.00
2.00		0.00	0	0	0		2.00
3.00	DIETARY	10.00	0	8	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	529	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,945	0		5.00
6.00	SOCIAL SERVICE	17.00	0	30	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	4,352	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	15	0		8.00
9.00	CLINIC	90.00	0	27,394	0		9.00
10.00		0.00	0	0	0		10.00
<b>TOTALS</b>			0	36,379			
<b>C - TO RECLASS SHORT &amp; LONG TERM LEASES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,489,386	10		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	5,771	0		2.00
3.00	DIETARY	10.00	0	417	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,675	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	50,772	0		5.00
6.00	CLINIC	90.00	0	347,750	0		6.00
<b>TOTALS</b>			0	1,901,771			
<b>D - TO RECLASS LAB COSTS TO CD</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	20,993	0		1.00
<b>TOTALS</b>			0	20,993			
<b>E - TO RECLASS COMMUNITY RELATIONS EXP</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	53,450	34,670	0		1.00
<b>TOTALS</b>			53,450	34,670			
<b>F - TO RECLASS PROPERTY TAX</b>							
1.00	OTHER CAP REL COSTS	3.00	0	303,009	13		1.00
2.00		0.00	0	0	13		2.00
<b>TOTALS</b>			0	303,009			
<b>G - TO RECLASS ECT COSTS</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	27,360	0		1.00
<b>TOTALS</b>			0	27,360			
<b>H - TO RECLASSIFY INTERST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	50,738	0		1.00
<b>TOTALS</b>			0	50,738			
<b>J - TO RECLASS DRIVERS TO ADMIN</b>							
1.00	CLINIC	90.00	27,830	5,848	0		1.00
2.00		0.00	0	0	0		2.00
<b>TOTALS</b>			27,830	5,848			
<b>K - TO RECLASS RADIOLOGY COSTS TO CD</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	6,060	0		1.00
<b>TOTALS</b>			0	6,060			
<b>L - TO RECLASS DRIVERS ADMIN TIME</b>							
1.00	CLINIC	90.00	0	316,753	0		1.00
<b>TOTALS</b>			0	316,753			
<b>M - RECLASS DEPRECIATION EXPENSE</b>							
1.00	CLINIC	90.00	0	56,657	9		1.00
<b>TOTALS</b>			0	56,657			
500.00	<b>Grand Total: Decreases</b>		81,280	2,760,238			500.00

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00 Land	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	0	0	0	0	0	3.00
4.00 Building Improvements	826,180	211,296	0	211,296	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	3,433,746	749,971	0	749,971	0	6.00
7.00 HIT designated Assets	0	0	0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	4,259,926	961,267	0	961,267	0	8.00
9.00 Reconciling Items	0	0	0	0	0	9.00
10.00 Total (line 8 minus line 9)	4,259,926	961,267	0	961,267	0	10.00

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

<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00 CAP REL COSTS-BLDG & FIXT	93,745	0	0	0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	555,540	0	0	0	0	2.00
3.00 Total (sum of lines 1-2)	649,285	0	0	0	0	3.00

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

<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT	1,037,476	0	1,037,476	0.198705	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	4,183,717	0	4,183,717	0.801295	0	2.00
3.00 Total (sum of lines 1-2)	5,221,193	0	5,221,193	1.000000	0	3.00

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
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	1,037,476	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	4,183,717	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	5,221,193	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	5,221,193	0			10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	93,745			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	555,540			2.00
3.00	Total (sum of lines 1-2)	0	649,285			3.00
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	93,745	1,900,289
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	596,766	0
3.00	Total (sum of lines 1-2)	0	0	0	690,511	1,900,289

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	14.00		
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,994,034	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	596,766	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,590,800	3.00

Cost Center Description		Basis/Code (2)		Expense Classification on worksheet A To/From which the Amount is to be Adjusted			
		1.00	2.00	3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-10,358		ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00	Television and radio service (chapter 21)		0			0.00	8.00
9.00	Parking lot (chapter 21)		0			0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,875,432			0.00	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0.00	12.00
13.00	Laundry and linen service		0			0.00	13.00
14.00	Cafeteria-employees and guests	B	-65,161		CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0			0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-686		MEDICAL RECORDS & LIBRARY	16.00	16.00
17.00	Sale of drugs to other than patients		0			0.00	17.00
18.00	Sale of medical records and abstracts		0			0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00	vending machines	B	-7,051		MAINTENANCE & REPAIRS	6.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	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 - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0		CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0			0.00	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	32.00
33.00	MHA LOBBYING EXPENSES	A	-7,021		ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	FRA	B	1,779,816		ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	SIGNATURE SERVICE AGREEMENT	B	-38,318		ADMINISTRATIVE & GENERAL	5.00	33.02
33.03	OTHER INCOME	B	-26,597		ADMINISTRATIVE & GENERAL	5.00	33.03
33.04	DONATIONS & GIFTS	B	-21,180		ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	TRANSPORTATION EXPENSES	A	-209,241		ADMINISTRATIVE & GENERAL	5.00	33.05
33.06	TRANSPORTATION BENEFITS	A	-1,998		EMPLOYEE BENEFITS	4.00	33.06
33.07	BAD DEBT	A	-2,415,223		ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	O/P TRANSPORTATION SALARIES	A	-87,957		CLINIC	90.00	33.08
33.09	O/P TRANSPORTATION BENEFITS	A	-18,482		EMPLOYEE BENEFITS	4.00	33.09
33.10	TRANSPORTATION VEHICLES DEPRECIATIO	A	-15,431		CAP REL COSTS-MVBLE EQUIP	2.00	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-4,020,320				50.00

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	0	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	0	24.00
25.00 Utilization review - physicians' compensation (chapter 21)	0	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00 Non-physician Anesthetist	0	28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	0	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	0	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00 MHA LOBBYING EXPENSES	0	33.00
33.01 FRA	0	33.01
33.02 SIGNATURE SERVICE AGREEMENT	0	33.02
33.03 OTHER INCOME	0	33.03
33.04 DONATIONS & GIFTS	0	33.04
33.05 TRANSPORTATION EXPENSES	0	33.05
33.06 TRANSPORTATION BENEFITS	0	33.06
33.07 BAD DEBT	0	33.07
33.08 O/P TRANSPORTATION SALARIES	0	33.08
33.09 O/P TRANSPORTATION BENEFITS	0	33.09
33.10 TRANSPORTATION VEHICLES DEPRECIATIO	9	33.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

	1.00	2.00	3.00	4.00	
	1.00	2.00	3.00	4.00	
	1.00	2.00	3.00	4.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	857,573	857,573	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,113,443	1,113,443	2.00
3.00	42.01	AGGREGATE-CHEMICAL DEPENDENCY	251,893	251,893	3.00
4.00	90.00	AGGREGATE-CLINIC	652,523	652,523	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			2,875,432	2,875,432	200.00

Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8-2 Date/Time Prepared: 5/29/2013 5:01 pm
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	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit
	5.00	6.00	7.00	8.00	9.00
1.00	0	0	0	0	0 1.00
2.00	0	0	0	0	0 2.00
3.00	0	0	0	0	0 3.00
4.00	0	0	0	0	0 4.00
5.00	0	0	0	0	0 5.00
6.00	0	0	0	0	0 6.00
7.00	0	0	0	0	0 7.00
8.00	0	0	0	0	0 8.00
9.00	0	0	0	0	0 9.00
10.00	0	0	0	0	0 10.00
200.00	0	0	0	0	0 200.00

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

Health Financial Systems  
 PROVIDER BASED PHYSICIAN ADJUSTMENT

CENTERPOINTE HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 264012

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

Worksheet A-8-2

Date/Time Prepared:  
 5/29/2013 5:01 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	857,573	1.00
2.00	0	1,113,443	2.00
3.00	0	251,893	3.00
4.00	0	652,523	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	0	0	10.00
200.00	0	2,875,432	200.00

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,994,034	1,994,034			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	596,766		596,766		2.00
4.00 00400	EMPLOYEE BENEFITS	3,890,696		8,023	3,925,529	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,037,060	26,810	52,234	622,505	4,886,334
6.00 00600	MAINTENANCE & REPAIRS	762,458	56,878	17,022	50,010	886,368
8.00 00800	LAUNDRY & LINEN SERVICE	80,836	7,240	2,167	0	90,243
9.00 00900	HOUSEKEEPING	348,829	14,199	4,250	0	367,278
10.00 01000	DIETARY	1,141,499	60,940	18,238	75,540	1,296,217
11.00 01100	CAFETERIA	-65,161	79,665	23,842	0	38,346
13.00 01301	NURSING ADMINISTRATION	820,420	12,188	3,648	191,240	1,027,496
16.00 01600	MEDICAL RECORDS & LIBRARY	590,965	11,263	3,371	89,652	695,251
17.00 01700	SOCIAL SERVICE	561,333	31,617	9,462	135,892	738,304
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,430,137	672,614	201,296	1,654,456	9,958,503
42.00 04200	SUBPROVIDER	0	0	0	0	0
42.01 04201	CHEMICAL DEPENDENCY	1,148,531	213,170	63,797	243,816	1,669,314
<b>ANCILLARY SERVICE COST CENTERS</b>						
57.00 05701	CT SCAN	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	231,523	34,674	10,377	28,307	304,881
73.00 07300	DRUGS CHARGED TO PATIENTS	904,879	6,939	2,077	12,443	926,338
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	4,823,687	590,095	176,601	808,633	6,399,016
90.01 09001	OUTPATIENT CLINIC	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,298,492	1,992,827	596,405	3,912,494	29,283,889
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	COMMUNITY RELATIONS	88,120	1,207	361	13,035	102,723
193.00 19301	NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	29,386,612	1,994,034	596,766	3,925,529	29,386,612

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

Worksheet 8  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,886,334					5.00
6.00	00600	176,777	1,063,145				6.00
8.00	00800	17,998	5,173	113,414			8.00
9.00	00900	73,250	10,146	0	450,674		9.00
10.00	01000	258,518	43,543	0	18,728	1,617,006	10.00
11.00	01100	7,648	56,922	0	24,483	297,888	11.00
13.00	01301	204,924	8,709	0	3,746	0	13.00
16.00	01600	138,661	8,048	0	3,461	0	16.00
17.00	01700	147,247	22,591	0	9,716	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,986,122	480,600	97,370	206,708	1,010,973	30.00
42.00	04200	0	0	0	0	0	42.00
42.01	04201	332,928	152,315	16,044	65,511	167,049	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	0	0	0	0	0	57.00
70.00	07000	60,805	24,775	0	10,656	0	70.00
73.00	07300	184,749	4,958	0	2,132	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,276,220	244,503	0	105,162	141,096	90.00
90.01	09001	0	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00							118.00
		4,865,847	1,062,283	113,414	450,303	1,617,006	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	20,487	862	0	371	0	190.01
193.00	19301	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		4,886,334	1,063,145	113,414	450,674	1,617,006	202.00

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		11.00	13.00	16.00	17.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	425,287					11.00
13.00	01301	23,690	1,268,565	867,972			13.00
16.00	01600	22,551	0	0	942,687		16.00
17.00	01700	24,829	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	279,274	1,089,113	780,298	885,899	16,774,860	30.00
42.00	04200	0	0	0	0	0	42.00
42.01	04201	43,280	179,452	43,837	56,788	2,726,518	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	0	0	0	0	0	57.00
70.00	07000	5,239	0	0	0	406,356	70.00
73.00	07300	2,050	0	0	0	1,120,227	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	24,374	0	43,837	0	8,234,208	90.00
90.01	09001	0	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		425,287	1,268,565	867,972	942,687	29,262,169	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	124,443	190.01
193.00	19301	0	0	0	0	0	193.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		425,287	1,268,565	867,972	942,687	29,386,612	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	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
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	01301	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	16,774,860
42.00	04200	SUBPROVIDER	0	0
42.01	04201	CHEMICAL DEPENDENCY	0	2,726,518
<b>ANCILLARY SERVICE COST CENTERS</b>				
57.00	05701	CT SCAN	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	406,356
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,120,227
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	8,234,208
90.01	09001	OUTPATIENT CLINIC	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	29,262,169
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
190.01	19001	COMMUNITY RELATIONS	0	124,443
193.00	19301	NONPAID WORKERS	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	29,386,612

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal 2A	EMPLOYEE BENEFITS 4.00	
		BLDG & FIXT 1.00	MVBLE EQUIP 2.00			
		0				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	8,023	34,833	34,833	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	174,535	226,769	5,524	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	56,878	17,022	73,900	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,240	2,167	9,407	8.00
9.00 00900	HOUSEKEEPING	0	14,199	4,250	18,449	9.00
10.00 01000	DIETARY	0	60,940	18,238	79,178	10.00
11.00 01100	CAFETERIA	0	79,665	23,842	103,507	11.00
13.00 01301	NURSING ADMINISTRATION	0	12,188	3,648	15,836	1,697
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,263	3,371	14,634	796
17.00 01700	SOCIAL SERVICE	0	31,617	9,462	41,079	1,206
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	672,614	201,296	873,910	14,679
42.00 04200	SUBPROVIDER	0	0	0	0	0
42.01 04201	CHEMICAL DEPENDENCY	0	213,170	63,797	276,967	2,164
<b>ANCILLARY SERVICE COST CENTERS</b>						
57.00 05701	CT SCAN	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	34,674	10,377	45,051	251
73.00 07300	DRUGS CHARGED TO PATIENTS	0	6,939	2,077	9,016	110
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	590,095	176,601	766,696	7,176
90.01 09001	OUTPATIENT CLINIC	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,992,827	596,405	2,589,232	34,717
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01 19001	COMMUNITY RELATIONS	0	1,207	361	1,568	116
193.00 19301	NONPAID WORKERS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	0	1,994,034	596,766	2,590,800	34,833

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	232,293					5.00
6.00	00600	8,404	82,748				6.00
8.00	00800	856	403	10,666			8.00
9.00	00900	3,482	790	0	22,721		9.00
10.00	01000	12,289	3,389	0	944	96,470	10.00
11.00	01100	364	4,430	0	1,234	17,772	11.00
13.00	01301	9,742	678	0	189	0	13.00
16.00	01600	6,592	626	0	175	0	16.00
17.00	01700	7,000	1,758	0	490	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	94,420	37,408	9,157	10,420	60,314	30.00
42.00	04200	0	0	0	0	0	42.00
42.01	04201	15,827	11,855	1,509	3,303	9,966	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	0	0	0	0	0	57.00
70.00	07000	2,891	1,928	0	537	0	70.00
73.00	07300	8,783	386	0	108	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	60,669	19,030	0	5,302	8,418	90.00
90.01	09001	0	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		231,319	82,681	10,666	22,702	96,470	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	974	67	0	19	0	190.01
193.00	19301	0	0	0	0	0	193.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		232,293	82,748	10,666	22,721	96,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

worksheet 8  
Part II  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		11.00	13.00	16.00	17.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	110,393					11.00
13.00	01301	6,149	34,291				13.00
16.00	01600	5,854	0	28,677			16.00
17.00	01700	6,445	0	0	57,978		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	72,492	29,440	25,781	54,485	1,282,506	30.00
42.00	04200	0	0	0	0	0	42.00
42.01	04201	11,234	4,851	1,448	3,493	342,617	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	0	0	0	0	0	57.00
70.00	07000	1,360	0	0	0	52,018	70.00
73.00	07300	532	0	0	0	18,935	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	6,327	0	1,448	0	875,066	90.00
90.01	09001	0	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		110,393	34,291	28,677	57,978	2,571,142	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	2,744	190.01
193.00	19301	0	0	0	0	0	193.00
200.00							200.00
201.00		16,914	0	0	0	16,914	201.00
202.00		127,307	34,291	28,677	57,978	2,590,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	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
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	01301	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0 1,282,506	30.00
42.00	04200	SUBPROVIDER	0 0	42.00
42.01	04201	CHEMICAL DEPENDENCY	0 342,617	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>				
57.00	05701	CT SCAN	0 0	57.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 52,018	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 18,935	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0 875,066	90.00
90.01	09001	OUTPATIENT CLINIC	0 0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0 0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE	0 0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0 2,571,142	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	190.00
190.01	19001	COMMUNITY RELATIONS	0 2,744	190.01
193.00	19301	NONPAID WORKERS	0 0	193.00
200.00		Cross Foot Adjustments	0 0	200.00
201.00		Negative Cost Centers	0 16,914	201.00
202.00		TOTAL (sum lines 118-201)	0 2,590,800	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,145				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		99,145			2.00
4.00	00400	EMPLOYEE BENEFITS	1,333	1,333	16,097,093		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,678	8,678	2,552,651	-4,886,334	24,500,278
6.00	00600	MAINTENANCE & REPAIRS	2,828	2,828	205,070	0	886,368
8.00	00800	LAUNDRY & LINEN SERVICE	360	360	0	0	90,243
9.00	00900	HOUSEKEEPING	706	706	0	0	367,278
10.00	01000	DIETARY	3,030	3,030	309,762	0	1,296,217
11.00	01100	CAFETERIA	3,961	3,961	0	0	38,346
13.00	01301	NURSING ADMINISTRATION	606	606	784,203	0	1,027,496
16.00	01600	MEDICAL RECORDS & LIBRARY	560	560	367,628	0	695,251
17.00	01700	SOCIAL SERVICE	1,572	1,572	557,241	0	738,304
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,443	33,443	6,784,303	0	9,958,503
42.00	04200	SUBPROVIDER	0	0	0	0	0
42.01	04201	CHEMICAL DEPENDENCY	10,599	10,599	999,797	0	1,669,314
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	CT SCAN	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,724	1,724	116,077	0	304,881
73.00	07300	DRUGS CHARGED TO PATIENTS	345	345	51,022	0	926,338
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	29,340	29,340	3,315,889	0	6,399,016
90.01	09001	OUTPATIENT CLINIC	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	99,085	99,085	16,043,643	-4,886,334	24,397,555
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	COMMUNITY RELATIONS	60	60	53,450	0	102,723
193.00	19301	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	1,994,034	596,766	3,925,529		4,886,334
203.00		Unit cost multiplier (wkst. B, Part I)	20.112300	6.019124	0.243866		0.199440
204.00		Cost to be allocated (per wkst. B, Part II)			34,833		232,293
205.00		Unit cost multiplier (wkst. B, Part II)			0.002164		0.009481

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID FTE'S)	
		6.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	73,980					6.00
8.00	00800	360	32,829				8.00
9.00	00900	706	0	72,914			9.00
10.00	01000	3,030	0	3,030	135,266		10.00
11.00	01100	3,961	0	3,961	24,919	1,867	11.00
13.00	01301	606	0	606	0	104	13.00
16.00	01600	560	0	560	0	99	16.00
17.00	01700	1,572	0	1,572	0	109	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	33,443	28,185	33,443	84,570	1,226	30.00
42.00	04200	0	0	0	0	0	42.00
42.01	04201	10,599	4,644	10,599	13,974	190	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	0	0	0	0	0	57.00
70.00	07000	1,724	0	1,724	0	23	70.00
73.00	07300	345	0	345	0	9	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	17,014	0	17,014	11,803	107	90.00
90.01	09001	0	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		73,920	32,829	72,854	135,266	1,867	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	60	0	60	0	0	190.01
193.00	19301	0	0	0	0	0	193.00
200.00							200.00
201.00							201.00
202.00		1,063,145	113,414	450,674	1,617,006	425,287	202.00
203.00		14,370,708	3,454,689	6,180,898	11,954,268	227,791,644	203.00
204.00		82,748	10,666	22,721	96,470	127,307	204.00
205.00		1,118,519	0,324,896	0,311,614	0,713,187	59,128,548	205.00

Cost Center Description		NURSING ADMINISTRATION (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01301	32,829			13.00
16.00	01600	0	99		16.00
17.00	01700	0	0	166	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	28,185	89	156	30.00
42.00	04200	0	0	0	42.00
42.01	04201	4,644	5	10	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>					
57.00	05701	0	0	0	57.00
70.00	07000	0	0	0	70.00
73.00	07300	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	0	5	0	90.00
90.01	09001	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
98.00	05950	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		32,829	99	166	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
193.00	19301	0	0	0	193.00
200.00					200.00
201.00					201.00
202.00		1,268,565	867,972	942,687	202.00
203.00		38,641,597	8,767,393,939	5,678,837,349	203.00
204.00		34,291	28,677	57,978	204.00
205.00		1,044,534	289,666,667	349,265,060	205.00

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	PPS
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	16,774,860		16,774,860	0	16,774,860	30.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
42.01	04201 CHEMICAL DEPENDENCY	2,726,518		2,726,518	0	2,726,518	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701 CT SCAN	0		0	0	0	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	406,356		406,356	0	406,356	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,120,227		1,120,227	0	1,120,227	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	8,234,208		8,234,208	0	8,234,208	90.00
90.01	09001 OUTPATIENT CLINIC	0		0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	29,262,169	0	29,262,169	0	29,262,169	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	29,262,169	0	29,262,169	0	29,262,169	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Title XVIII

Hospital

PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	25,343,119			30.00
42.00	04200	SUBPROVIDER	0			42.00
42.01	04201	CHEMICAL DEPENDENCY	2,581,250			42.01
<b>ANCILLARY SERVICE COST CENTERS</b>						
57.00	05701	CT SCAN	0	0	0.000000	57.00
70.00	07000	ELECTROENCEPHALOGRAPHY	845,896	1,265,432	0.192465	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,386,580	190,459	0.313172	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	36,903,658	0.223127	90.00
90.01	09001	OUTPATIENT CLINIC	0	0	0.000000	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	32,156,845	38,359,549	70,516,394	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	32,156,845	38,359,549	70,516,394	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Title XVIII

Hospital

PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS		30.00
42.00	04200 SUBPROVIDER		42.00
42.01	04201 CHEMICAL DEPENDENCY		42.01
<b>ANCILLARY SERVICE COST CENTERS</b>			
57.00	05701 CT SCAN	0.000000	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.192465	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.313172	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	0.223127	90.00
90.01	09001 OUTPATIENT CLINIC	0.000000	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>			
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital			Total Costs	
			Title XIX		Cost		
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		16,774,860			0	30.00
42.00	04200 SUBPROVIDER		0			0	42.00
42.01	04201 CHEMICAL DEPENDENCY		2,726,518			0	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701 CT SCAN		0			0	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY		406,356			0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,120,227			0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		8,234,208			0	90.00
90.01	09001 OUTPATIENT CLINIC		0			0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0			0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)		29,262,169	0		0	200.00
201.00	Less Observation Beds		0			0	201.00
202.00	Total (see instructions)		29,262,169	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Title XIX			Hospital	Cost
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
		Inpatient	Outpatient	Total (col. 6 + col. 7)		
6.00	7.00	8.00	9.00	10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	25,343,119		25,343,119	30.00
42.00	04200	SUBPROVIDER	0		0	42.00
42.01	04201	CHEMICAL DEPENDENCY	2,581,250		2,581,250	42.01
<b>ANCILLARY SERVICE COST CENTERS</b>						
57.00	05701	CT SCAN	0	0	0	0.000000 57.00
70.00	07000	ELECTROENCEPHALOGRAPHY	845,896	1,265,432	2,111,328	0.192465 70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,386,580	190,459	3,577,039	0.313172 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	36,903,658	36,903,658	0.223127 90.00
90.01	09001	OUTPATIENT CLINIC	0	0	0	0.000000 90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000 98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	32,156,845	38,359,549	70,516,394	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	32,156,845	38,359,549	70,516,394	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
42.00	04200 SUBPROVIDER				42.00
42.01	04201 CHEMICAL DEPENDENCY				42.01
<b>ANCILLARY SERVICE COST CENTERS</b>					
57.00	05701 CT SCAN	0.000000			57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 OUTPATIENT CLINIC	0.000000			90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 264012

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

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	
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,282,506	0	1,282,506	28,185	45.50	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0.00	42.00
42.01	04201	CHEMICAL DEPENDENCY	342,617	0	342,617	4,644	73.78	42.01
200.00		Total (lines 30-199)	1,625,123		1,625,123	32,829		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 264012

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	6,741	306,716	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
42.01	04201	CHEMICAL DEPENDENCY	0	0	42.01
200.00		Total (lines 30-199)	6,741	306,716	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 264012		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/29/2013 5:01 pm	
Title XVIII			Hospital		PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701 CT SCAN	0	0	0.000000	0	0	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	52,018	2,111,328	0.024638	335,656	8,270	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,935	3,577,039	0.005293	1,279,761	6,774	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	875,066	36,903,658	0.023712	0	0	90.00
90.01	09001 OUTPATIENT CLINIC	0	0	0.000000	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	946,019	42,592,025		1,615,417	15,044	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D  
Part III  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description	Title XVIII			Hospital	Total Costs (sum of cols. 1 through 3, minus col. 4)	PPS
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
42.01 04201 CHEMICAL DEPENDENCY	0	0	0	0	0	42.01
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS      Provider CCN: 264012      Period: From 01/01/2012 To 12/31/2012      Worksheet D Part III Date/Time Prepared: 5/29/2013 5:01 pm

Cost Center Description			Title XVIII		Hospital		PSA Adj. Nursing School	
			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	28,185	0.00	6,741	0	0	30.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
42.01	04201	CHEMICAL DEPENDENCY	4,644	0.00	0	0	0	42.01
200.00		Total (lines 30-199)	32,829		6,741	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/29/2013 5:01 pm
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Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS			12.00	13.00	
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
42.01	04201	CHEMICAL DEPENDENCY	0	0	42.01
200.00		Total (lines 30-199)	0	0	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701 CT SCAN	0	0	0.000000	0.000000	0	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,111,328	0.000000	0.000000	335,656	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,577,039	0.000000	0.000000	1,279,761	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	36,903,658	0.000000	0.000000	0	90.00
90.01	09001 OUTPATIENT CLINIC	0	0	0.000000	0.000000	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (lines 50-199)	0	42,592,025			1,615,417	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet 0 Part IV Date/Time Prepared: 5/29/2013 5:01 pm

Cost Center Description		Title XVIII			Hospital		
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701	CT SCAN	0	0	0	0	57.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	312,228	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,152	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	16,738,580	0	0	90.00
90.01	09001	OUTPATIENT CLINIC	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	17,054,960	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 5:01 pm
	Title XVIII	Hospital	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
57.00	05701 CT SCAN	0	0	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OUTPATIENT CLINIC	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 264012		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part V Date/Time Prepared: 5/29/2013 5:01 pm		
		Title XVIII		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
57.00	05701	CT SCAN	0.000000	0	0	0	0	57.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.192465	312,228	0	0	60,093	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313172	4,152	0	0	1,300	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.223127	16,738,580	0	0	3,734,829	90.00
90.01	09001	OUTPATIENT CLINIC	0.000000	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		17,054,960	0	0	3,796,222	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		17,054,960	0	0	3,796,222	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 5:01 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
57.00 05701 CT SCAN	0	0		57.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OUTPATIENT CLINIC	0	0		90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Subtotal (see instructions)				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00



Health Financial Systems		CENTERPOINTE HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
					Date/Time Prepared: 5/29/2013 5:01 pm
			Title XVIII		Hospital PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				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)				465,387
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				4,477,428
	PASS THROUGH COST ADJUSTMENTS				
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)				306,716
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)				15,044
52.00	Total Program excludable cost (sum of lines 50 and 51)				321,760
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				4,155,668
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
	PART XII - 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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet 0-1

Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description	Title XVIII			Hospital	PPS	
	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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	1,282,506	16,774,860	0.076454	0	0	90.00
91.00 Nursing School cost	0	16,774,860	0.000000	0	0	91.00
92.00 Allied health cost	0	16,774,860	0.000000	0	0	92.00
93.00 All other Medical Education	0	16,774,860	0.000000	0	0	93.00

Title XIX		Hospital	Cost
Cost Center Description			1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>			
<b>INPATIENT DAYS</b>			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,185	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,185	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)	28,185	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)	5,674	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
<b>SWING-BED ADJUSTMENT</b>			
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)	16,774,860	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)	16,774,860	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
28.00	General inpatient routine service charges (excluding swing-bed charges)	25,343,119	28.00
29.00	Private room charges (excluding swing-bed charges)	25,343,119	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.661910	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	16,774,860	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>			
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	595.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,376,995	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)	3,376,995	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:  
5/29/2013 5:01 pm

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
<b>Intensive Care Type Inpatient Hospital Units</b>						
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
<b>Cost Center Description</b>						1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					121,269	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,498,264	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54.00 Program discharges					0.00	54.00
55.00 Target amount per discharge					0	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)					0.00	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	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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					0.00	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 264012

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

Worksheet D-3

Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)			
		1.00	2.00	3.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		6,193,342				30.00
42.00	04200 SUBPROVIDER		0				42.00
42.01	04201 CHEMICAL DEPENDENCY		0				42.01
<b>ANCILLARY SERVICE COST CENTERS</b>							
57.00	05701 CT SCAN	0.000000	0			0	57.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.192465	335,656	64,602		70.00	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.313172	1,279,761	400,785		73.00	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.223127	0			0	90.00
90.01	09001 OUTPATIENT CLINIC	0.000000	0			0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0			0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		1,615,417	465,387		200.00	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0			201.00	201.00
202.00	Net Charges (line 200 minus line 201)		1,615,417			202.00	202.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 5:01 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,796,222		2.00
3.00	PPS payments	4,618,929		3.00
4.00	Outlier payment (see instructions)	0		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	23,111		5.00
6.00	Line 2 times line 5	87,734,487		6.00
7.00	Sum of line 3 plus line 4 divided by line 6	5.26		7.00
8.00	Transitional corridor payment (see instructions)	0		8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200	0		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0		11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000		17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,618,929		24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		14,521	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		927,852	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		3,676,556	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,676,556	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,676,556	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		89,226	33.00
34.00	Allowable bad debts (see instructions)		62,458	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		32,975	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,739,014	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		5,074	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		3,733,940	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		3,771,962	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		-38,022	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0.00	91.00
92.00	The rate used to calculate the Time Value of Money			0 92.00
93.00	Time value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 264012

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

Worksheet E  
Part 8  
Date/Time Prepared:  
5/29/2013 5:01 pm

Title XVIII

Hospital

PPS

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 264012

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2013 5:01 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,153,860		3,671,482	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
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER	12/31/2012	78,400	12/31/2012	100,480	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
<b>Provider to Program</b>						
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)		78,400		100,480	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)		4,232,260		3,771,962	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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		63,322		38,022	6.01
6.02	SETTLEMENT TO PROGRAM		0		3,733,940	6.02
7.00	Total Medicare program liability (see instructions)		4,295,582			7.00
			0			
				Contractor Number	Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 264012	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/29/2013 5:01 pm
Title XVIII		Hospital	PPS
			1.00

Line	Description	Amount	Rate
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4,671,727	1.00
2.00	Net IPF PPS Outlier Payments	79,298	2.00
3.00	Net IPF PPS ECT Payments	22,240	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)	77.008197	9.00
10.00	Medical Education Adjustment Factor {(1 + (line 8/line 9)) 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)	4,773,265	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)	4,773,265	16.00
17.00	Primary payer payments	68,296	17.00
18.00	Subtotal (line 16 less line 17).	4,704,969	18.00
19.00	Deductibles	350,932	19.00
20.00	Subtotal (line 18 minus line 19)	4,354,037	20.00
21.00	Coinsurance	169,932	21.00
22.00	Subtotal (line 20 minus line 21)	4,184,105	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	159,253	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	111,477	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	4,295,582	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)	4,295,582	31.00
32.00	Interim payments	4,232,260	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)	63,322	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>			
50.00	Original outlier amount from worksheet E-3, Part II, line 2	79,298	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: 264012

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

Worksheet E-3  
Part VII  
Date/Time Prepared:  
5/29/2013 5:01 pm

		Title XIX		Hospital		Cost	
				Inpatient	Outpatient		
				1.00	2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>							
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>							
1.00	Inpatient hospital/SNF/NF services		3,498,264			0	1.00
2.00	Medical and other services					0	2.00
3.00	Organ acquisition (certified transplant centers only)		0			0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,498,264			0	4.00
5.00	Inpatient primary payer payments		0			0	5.00
6.00	Outpatient primary payer payments					0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,498,264			0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>							
<b>Reasonable Charges</b>							
8.00	Routine service charges		5,368,217			0	8.00
9.00	Ancillary service charges		387,228			0	9.00
10.00	Organ acquisition charges, net of revenue		0			0	10.00
11.00	Incentive from target amount computation		0			0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		5,755,445			0	12.00
<b>CUSTOMARY CHARGES</b>							
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)		5,755,445			0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,257,181			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)		3,498,264			0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>							
22.00	Other than outlier payments		0			0	22.00
23.00	Outlier payments		0			0	23.00
24.00	Program capital payments		0			0	24.00
25.00	Capital exception payments (see instructions)		0			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)		3,498,264			0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>							
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)		3,498,264			0	31.00
32.00	Deductibles		0			0	32.00
33.00	Coinsurance		0			0	33.00
34.00	Allowable bad debts (see instructions)		0			0	34.00
35.00	Utilization review		0			0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,498,264			0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			0	37.00
38.00	Subtotal (line 36 ± line 37)		3,498,264			0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0			0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,498,264			0	40.00
41.00	Interim payments		2,304,611			0	41.00
42.00	Balance due provider/program (line 40 minus 41)		1,193,653			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: 264012

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

Worksheet G

Date/Time Prepared:  
5/29/2013 5:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-507,071	0	0	0	1.00
2.00	Temporary investments	213,732	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,947,806	0	0	0	4.00
5.00	Other receivable	263,144	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,133,730	0	0	0	6.00
7.00	Inventory	182,901	0	0	0	7.00
8.00	Prepaid expenses	135,092	0	0	0	8.00
9.00	Other current assets	32,100	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,133,974	0	0	0	11.00
<b>FIXED ASSETS</b>						
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	1,037,476	0	0	0	17.00
18.00	Accumulated depreciation	-343,900	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	392,516	0	0	0	21.00
22.00	Accumulated depreciation	-387,750	0	0	0	22.00
23.00	Major movable equipment	3,791,201	0	0	0	23.00
24.00	Accumulated depreciation	-2,236,001	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)	2,253,542	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,387,516	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	617,945	0	0	0	37.00
38.00	Salaries, wages, and fees payable	536,610	0	0	0	38.00
39.00	Payroll taxes payable	207,139	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	-408,609	0	0	0	43.00
44.00	Other current liabilities	716,871	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,669,956	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	1,500,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,500,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,169,956	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	6,217,560	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,217,560	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,387,516	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 264012

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

Worksheet G-1

Date/Time Prepared:  
5/29/2013 5:01 pm

	General Fund		Special Purpose Fund		Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00 Fund balances at beginning of period		6,006,051			0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		486,507				2.00
3.00 Total (sum of line 1 and line 2)		6,492,558			0	3.00
4.00 Additions (credit adjustments) (specify)			0		0	4.00
5.00 CHANGE IN PRIOR YEARS NET INCOME	344,016		0		0	5.00
6.00	0		0		0	6.00
7.00	0		0		0	7.00
8.00	0		0		0	8.00
9.00	0		0		0	9.00
10.00 Total additions (sum of line 4-9)		344,016			0	10.00
11.00 Subtotal (line 3 plus line 10)		6,836,574			0	11.00
12.00 Deductions (debit adjustments) (specify)			0		0	12.00
13.00 CHANGE IN PARTNERS CAPITAL	396,041		0		0	13.00
14.00 CHANGE IN RETAINED EARNINGS	222,973		0		0	14.00
15.00	0		0		0	15.00
16.00	0		0		0	16.00
17.00	0		0		0	17.00
18.00 Total deductions (sum of lines 12-17)		619,014			0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		6,217,560			0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 264012

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

worksheet G-1

Date/Time Prepared:  
5/29/2013 5:01 pm

		Plant Fund			
		Endowment 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	CHANGE IN PRIOR YEARS NET INCOME		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	CHANGE IN PARTNERS CAPITAL		0		13.00
14.00	CHANGE IN RETAINED EARNINGS		0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 264012

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2013 5:01 pm

Cost Center Description		Inpatient 1.00	Outpatient 2.00	Total 3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	24,750,490		24,750,490	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER	0		0	4.00
4.01	CHEMICAL DEPENDENCY	2,581,250		2,581,250	4.01
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)	27,331,740		27,331,740	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
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)	27,331,740		27,331,740	17.00
18.00	Ancillary services	4,888,000		6,343,891	18.00
19.00	Outpatient services	0	1,455,891	37,909,458	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	0	0	0	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)	32,219,740	39,365,349	71,585,089	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		33,406,932		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	0	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)		33,406,932		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 264012

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

Worksheet G-3

Date/Time Prepared:  
5/29/2013 5:01 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	71,585,089	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,448,058	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,137,031	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	33,406,932	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,730,099	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	21,180	6.00
7.00	Income from investments	10,358	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	65,161	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	686	17.00
18.00	Revenue from sale of medical records and abstracts	2,282	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	7,051	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	-2,415,223	23.00
24.00	BAD DEBTS	38,317	24.00
24.01	SERVICE AGREEMENT	26,596	24.01
24.02	OTHER INCOME	-2,243,592	24.02
25.00	Total other income (sum of lines 6-24)	486,507	25.00
26.00	Total (line 5 plus line 25)	486,507	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	486,507	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		29.00

SPECIAL REPORTS - Interns & Residents to Beds Ratio Report

Provider CCN: 264012

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

Interns & Residents  
Date/Time Prepared:  
5/29/2013 5:01 pm

1.00

Subject: Interns & Residents to Beds Ratio Update (Operating IME)  
Interns & Residents to Average Daily Census Ratio Update (Capital IME)

Please make the following changes in order to update the Provider Specific file:

Ref: CMS PUB. 100-04, SEC 20.2.3

INTERNS & RESIDENTS / BEDS RATIO FOR OPERATING PPS

1.00	Number of Beds (E Pt A Ln 4)	104.00	1.00
2.00	Number of FTE Interns & Residents (E Pt A Ln 15)	0.00	2.00
3.00	Current Yr resident to bed ratio (E Pt A Ln 19)	0.0000	3.00
4.00	Prior Yr resident to bed ratio (E Pt A Ln 20)	0.0000	4.00
5.00	Lesser of Ln 3 or Ln 4 (E Pt A Ln 21)	0.0000	5.00
6.00	Section 422 Add-on FTE (E Pt A Ln 25)	0.00	6.00
7.00	Total IME Payment (E Pt A Ln 29)	0	7.00
8.00	DRG + HMO DRG (E Pt A Lns 1 + 3)	0	8.00
9.00	FISS PSF Intern to bed ratio $((Ln 7 / Ln 8) / 1.35) + 1) \wedge (1/0.405)) - 1$	0.0000	9.00
INTERNS & RESIDENTS / Average Daily Census Ratio for Capital PPS			
20.00	Number of FTE Interns & Residents (L, Ln 4)	0.00	20.00
21.00	Average Daily Census for PPS Hospital (L, Ln 3)	0.00	21.00
22.00	Ratio of Interns & Residents / Average Daily Census - Ln 20 / Ln 21 (round to four decimal places)	0.0000	22.00

The information for this update was taken from:

- \_\_\_\_\_ Information supplied by the provider
- \_\_\_\_\_ Final Settled Cost Report for FYE: 12/31/2012
- \_\_\_\_\_ Other (Specify)

		Hospital	PPS
			1.00
<b>PSYCH RATIO OF COST TO CHARGES (RCC) REPORT (PER CR7609)</b>			
1.00	Total program cost (D-1 Pt II Line 49.00 minus E-3 Pt II line 28)	4,477,428	1.00
2.00	Total program charges (D-3 Col 2 sum of lines 30-35 if hospital or line 40 if sub-provider plus D-3 Col 2 Line 202; where possible, these charges should be confirmed with the PS&R data)	7,808,759	2.00
3.00	Psych unit Ratio of Cost to Charges (Line 1 divided by line 2)	0.573	3.00
<b>PSYCH RESIDENTS TO AVERAGE DAILY CENSUS REPORT</b>			
11.00	W/S E-3, Pt II Line 8 I&R PPS Med Ed Adj	0.00	11.00
12.00	W/S E-3, Pt II Line 9 Ave Daily Census	0.000000	12.00
13.00	Psych Residents Average Daily Census	0.0000	13.00
<b>PSYCH NATIONAL URBAN &amp; RURAL COST TO CHARGE RATIOS FOR THE IPF PPS FY 2013 (PER CR#8000)</b>			
21.00	Urban Median	0.4960	21.00
22.00	Urban Ceiling	1.7072	22.00
23.00	Rural Median	0.6220	23.00
24.00	Rural Ceiling	1.9155	24.00
<b>BED SIZE</b>			
31.00	Bed Size (W/S S-3, Pt I Line 16 Col 2)	0.00	31.00

SPECIAL REPORTS - OPPS RCC REPORT WITH PARAMED, ED & ALLIED HEALTH  
 COSTS EXCLUDED

Provider CCN: 264012

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

OPPS RCC Report  
 Date/Time Prepared:  
 5/29/2013 5:01 pm

Cost Center Description		Cost/Charge Ratio	PPS Services FYB to 12/31	PPS Services 1/1 to FYE	Total Charges (C)	Total Costs (C)	
		1.00	2.00	2.01	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS (B)</b>							
57.00	CT SCAN	0.000000	0	0	0	0	57.00
70.00	ELECTROENCEPHALOGRAPHY	0.192465	312,228	0	312,228	60,093	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.313102	4,152	0	4,152	1,300	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0.223127	16,738,580	0	16,738,580	3,734,829	90.00
90.01	OUTPATIENT CLINIC	0.000000	0	0	0	0	90.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
202.00	Total		17,054,960	0	17,054,960	3,796,222	202.00
<b>RCC Calculation (B)</b>							
211.00	Total Cost (Col 4, Line 202 which equals D Pt V col 5, Line 200)					3,796,222	211.00
212.00	Total Charges (Col 3, Line 202 which equals D Pt V col 2 and subscripts, Line 200)					17,054,960	212.00
213.00	OPPS / Charge Ratio (OPPS Cost/Charge Ratio Max is 1.400)					0.223	213.00
<b>Statewide Average Operating RCC</b>							
214.00	Urban					0.262	214.00
215.00	Rural					0.241	215.00
<b>Section II - Bed Size</b>							
221.00	Bed Size (E Pt A line 4 logic)					104.00	221.00
<b>Section III - Non Opps RCC for FISS-Core, 41 Screen, Page 3</b>							
231.00	w/S E Part B, line 1, col 1					0	231.00
232.00	w/S E Part B line 12, col 1					0	232.00
233.00	Non OPPS RCC (line 231 / line 232)					0.000	233.00

(A) Cost/Charge Ratio Calculated after omitting the Costs for Paramed Ed & Allied Health  
 (B) worksheet A line numbers. If lines 96-97 present, review to ensure that "Non Implantable DME" is Excluded  
 (C) wks A lines 61, 66-68, 74, 88, 89, 94, 95 are not included in Totals