

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/31/2013 8:08 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/31/2013 Time: 8:08 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLARK MEMORIAL HOSPITAL (150009) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-763,478	-240,887	162,486	0	1.00
2.00 Subprovider - IPF	0	10,487	1		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-752,991	-240,886	162,486	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 150009		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 8:07 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1220 MISSOURI AVENUE			PO Box: 69							1.00	
2.00	City: JEFFERSONVILLE			State: IN		Zip Code: 47130		County: CLARK			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
				V	XVIII	XIX						
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		CLARK MEMORIAL HOSPITAL	150009	31140	1	07/01/1966	N	P	P	3.00	
4.00	Subprovider - IPF		BEHAVIORAL MEDICINE UNIT	15S009	31140	4	01/01/1992	N	P	N	4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF										7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital-Based SNF										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)						9		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						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.						2	N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,986	832	192	140	3,573	0		24.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00			
							Urban/Rural S	Date of Geogr				
							1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 8:07 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		Y			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.		N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.		N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150009

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

Worksheet S-2
Part I
Date/Time Prepared:
5/31/2013 8:07 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 8:07 am		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N			80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150009			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/31/2013 8:07 am		
								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/31/2013 8:07 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/02/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/31/2013 8:07 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD		BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435		LV COSTREPORTS@BKD.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/02/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150009

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2013 8:07 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps		
					Title V		
	1.00	2.00	3.00	4.00	5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	135	51,809	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)		135	51,809	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	34	12,444	0.00	0	8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY	43.00				0	13.00	
14.00 Total (see instructions)		169	64,253	0.00	0	14.00	
15.00 CAH visits					0	15.00	
16.00 SUBPROVIDER - IPF	40.00	20	7,320		0	16.00	
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00	
18.00 SUBPROVIDER	42.00	0	0		0	18.00	
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPI CE						24.00	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)		189				27.00	
28.00 Observation Bed Days					0	28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
33.00 LTCH non-covered days						33.00	
				I/P Days / O/P Visi ts / Tri ps		Full Time Equival ents	
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol l		
	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)	19,494	3,835	42,912			1.00	
2.00 HMO	4,316	4,737				2.00	
3.00 HMO IPF Subprovider	99	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)	19,494	3,835	42,912			7.00	
8.00 INTENSIVE CARE UNIT	4,870	845	9,453			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		306	3,429			13.00	
14.00 Total (see instructions)	24,364	4,986	55,794	2.59	1,158.59	14.00	
15.00 CAH visits	0	0	0			15.00	
16.00 SUBPROVIDER - IPF	3,289	0	3,892	0.00	20.01	16.00	
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00	
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00	
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPI CE						24.00	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150009

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2013 8:07 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
27.00	Total (sum of lines 14-26)					2.59	27.00
28.00	Observation Bed Days					1,178.60	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00
Component	Full Time Equivalents	Discharges					
	Nonpaid Workers	Title V	Title VIII	Title XIX	Total All Patients		
	11.00	12.00	13.00	14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)					5,408	1.00
2.00	HMO					973	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)					5,408	14.00
15.00	CAH visits					1,164	15.00
16.00	SUBPROVIDER - IPF					287	16.00
17.00	SUBPROVIDER - IRF					0	17.00
18.00	SUBPROVIDER					0	18.00
19.00	SKILLED NURSING FACILITY					0	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)					5,408	27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150009

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2013 8:07 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	57,767,370	0	57,767,370	2,451,485.06	23.56
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		116,517	0	116,517	5,059.39	23.03
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,425,477	-147,595	1,277,882	56,528.22	22.61
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		19,658	0	19,658	353.75	55.57
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		11,761,397	0	11,761,397		
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		258,776	0	258,776		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		27,868	0	27,868		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	318,551	0	318,551	12,045.85	26.44
27.00	Administrative & General	5.00	8,586,297	0	8,586,297	336,105.01	25.55
28.00	Administrative & General under contract (see inst.)		400,811	0	400,811	4,947.33	81.02
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,189,151	0	1,189,151	60,175.60	19.76
31.00	Laundry & Linen Service	8.00	127,446	0	127,446	10,482.75	12.16
32.00	Housekeeping	9.00	1,595,856	0	1,595,856	120,568.18	13.24
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,470,819	0	1,470,819	113,689.75	12.94
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	421,025	0	421,025	11,814.75	35.64
39.00	Central Services and Supply	14.00	361,702	0	361,702	23,464.86	15.41
40.00	Pharmacy	15.00	2,225,681	0	2,225,681	60,824.93	36.59
41.00	Medical Records & Medical Records Library	16.00	1,484,998	0	1,484,998	78,303.44	18.96

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150009

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2013 8:07 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	1,747,340	0	1,747,340	56,783.29	30.77	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150009

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

Worksheet S-3
Part III
Date/Time Prepared:
5/31/2013 8:07 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	58,051,664	0	58,051,664	2,451,373.00	23.68	1.00
2.00	Excluded area salaries (see instructions)	1,425,477	-147,595	1,277,882	56,528.22	22.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	56,626,187	147,595	56,773,782	2,394,844.78	23.71	3.00
4.00	Subtotal other wages & related costs (see inst.)	19,658	0	19,658	353.75	55.57	4.00
5.00	Subtotal wage-related costs (see inst.)	11,761,397	0	11,761,397	0.00	20.72	5.00
6.00	Total (sum of lines 3 thru 5)	68,407,242	147,595	68,554,837	2,395,198.53	28.62	6.00
7.00	Total overhead cost (see instructions)	19,929,677	0	19,929,677	889,205.74	22.41	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2013 8:07 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,129,507	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		34,305	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		5,954,996	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		235,449	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		14,103	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		9,171	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		223,445	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		4,246,089	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		65,541	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		138,445	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		12,051,051	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/31/2013 8:07 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice			0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/31/2013 8:07 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.357849	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		34,873,072	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		53,387,331	6.00	
7.00	Medicaid cost (line 1 times line 6)		19,104,603	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,715,844	3,627,364	9,343,208	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,045,409	1,298,049	3,343,458	21.00
22.00	Partial payment by patients approved for charity care	11,427	13,108	24,535	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,033,982	1,284,941	3,318,923	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		31,739,000	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		354,567	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		31,384,433	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		11,230,888	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		14,549,811	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,549,811	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150009		Period: From 01/01/2012 To 12/31/2012		Worksheet A			
Date/Time Prepared: 5/31/2013 8:07 am									
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		10,545,312		10,545,312	-4,208,562	6,336,750	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0		0	6,710,412	6,710,412	2.00
4.00	00400	EMPLOYEE BENEFITS	318,551	13,657,704	13,976,255		-30,453	13,945,802	4.00
5.01	00510	NONPATIENT TELEPHONES	287,899	303,928	591,827		-9,686	582,141	5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	617,718	111,364	729,082		203,761	932,843	5.02
5.03	00512	ADMINISTRATIVE	1,320,468	147,762	1,468,230		-391	1,467,839	5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE	1,106,745	924,737	2,031,482		-47	2,031,435	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	5,253,467	26,217,957	31,471,424		70,640	31,542,064	5.05
7.00	00700	OPERATION OF PLANT	1,189,151	5,429,639	6,618,790		82,097	6,700,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,446	850,605	978,051		-12	978,039	8.00
9.00	00900	HOUSEKEEPING	1,595,856	334,899	1,930,755		-9,772	1,920,983	9.00
10.00	01000	DIETARY	1,470,819	1,693,769	3,164,588		-14,520	3,150,068	10.00
11.00	01100	CAFETERIA	0	0	0		0	0	11.00
13.00	01300	NURSING ADMINISTRATION	421,025	10,485	431,510		-6	431,504	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	361,702	363,154	724,856		-122,755	602,101	14.00
15.00	01500	PHARMACY	2,225,681	7,430,134	9,655,815		328	9,656,143	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,484,998	609,767	2,094,765		-116,776	1,977,989	16.00
17.00	01700	SOCIAL SERVICE	1,747,340	582,417	2,329,757		-1,670	2,328,087	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0		0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		116,517	116,517	22.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	11,155,821	1,172,541	12,328,362		-476,522	11,851,840	30.00
31.00	03100	INTENSIVE CARE UNIT	4,020,823	727,698	4,748,521		-462,556	4,285,965	31.00
40.00	04000	SUBPROVIDER - I/PF	1,036,329	135,902	1,172,231		-171,412	1,000,819	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0		0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0		0	0	42.00
43.00	04300	NURSERY	783,313	108,871	892,184		-97,590	794,594	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,252	3,252		-3,252	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,979,139	12,749,329	16,728,468		-9,591,292	7,137,176	50.00
51.00	05100	RECOVERY ROOM	939,888	242,562	1,182,450		-485,301	697,149	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,343,303	443,859	1,787,162		-44	1,787,118	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,040,415	2,978,748	7,019,163		-1,716,547	5,302,616	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,095,410	5,871,148	6,966,558		-57	6,966,501	59.00
60.00	06000	LABORATORY	2,791,335	3,449,165	6,240,500		-22,841	6,217,659	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,283,706	1,283,706		-1,155,707	127,999	63.00
64.00	06400	INTRAVENOUS THERAPY	221,653	380,158	601,811		0	601,811	64.00
65.00	06500	RESPIRATORY THERAPY	1,519,443	924,183	2,443,626		-101,622	2,342,004	65.00
66.00	06600	PHYSICAL THERAPY	769,199	23,597	792,796		-13,137	779,659	66.00
69.00	06900	ELECTROCARDIOLOGY	507,595	51,207	558,802		-23,058	535,744	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,817	66,373	123,190		-2,340	120,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		8,904,785	8,904,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		6,065,853	6,065,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		0	0	73.00
74.00	07400	RENAL DIALYSIS	0	332,056	332,056		0	332,056	74.00
76.00	03021	DIABETES	0	0	0		0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	126,294	7,864	134,158		0	134,158	76.01
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	3,462,579	1,181,776	4,644,355		-675,817	3,968,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE		2,752,502	2,752,502		-2,583,517	168,985	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,378,222	104,100,130	161,478,352		57,131	161,535,483	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	0	190.00
194.00	07950	SIRH	255,294	71,397	326,691		-58,012	268,679	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	133,854	609,565	743,419		881	744,300	194.01
200.00		TOTAL (SUM OF LINES 118-199)	57,767,370	104,781,092	162,548,462		0	162,548,462	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150009

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

Worksheet A
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-365,560	5,971,190	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-78,792	6,631,620	2.00
4.00	00400	EMPLOYEE BENEFITS	7,883	13,953,685	4.00
5.01	00510	NONPATIENT TELEPHONES	0	582,141	5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	0	932,843	5.02
5.03	00512	ADMITTING	0	1,467,839	5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE	0	2,031,435	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-3,195,373	28,346,691	5.05
7.00	00700	OPERATION OF PLANT	-208,983	6,491,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	978,039	8.00
9.00	00900	HOUSEKEEPING	0	1,920,983	9.00
10.00	01000	DIETARY	-894,158	2,255,910	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	431,504	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8,534	593,567	14.00
15.00	01500	PHARMACY	-11,376	9,644,767	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,381	1,959,608	16.00
17.00	01700	SOCIAL SERVICE	0	2,328,087	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	116,517	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,855	11,849,985	30.00
31.00	03100	INTENSIVE CARE UNIT	-10,406	4,275,559	31.00
40.00	04000	SUBPROVIDER - I PF	-82,193	918,626	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	794,594	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,394,523	5,742,653	50.00
51.00	05100	RECOVERY ROOM	0	697,149	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-90,000	1,697,118	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,495	5,294,121	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,966,501	59.00
60.00	06000	LABORATORY	-72,842	6,144,817	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	127,999	63.00
64.00	06400	INTRAVENOUS THERAPY	16,481	618,292	64.00
65.00	06500	RESPIRATORY THERAPY	-24,045	2,317,959	65.00
66.00	06600	PHYSICAL THERAPY	0	779,659	66.00
69.00	06900	ELECTROCARDIOLOGY	0	535,744	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	120,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,904,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,065,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	332,056	74.00
76.00	03021	DIABETES	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0	134,158	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-15,082	3,953,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-168,985	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,625,219	154,910,264	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	SIRH	0	268,679	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	744,300	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-6,625,219	155,923,243	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INTERNS & RESIDENTS					
1.00	I&R SERVICES-OTHER PRGM	22.00		116,517	1.00
	COSTS APPRVD				
2.00		0.00	0	0	2.00
	TOTALS		0	116,517	
B - NEW DIRECTIONS ADMIN					
1.00	ADULTS & PEDIATRICS	30.00	147,595	8,669	1.00
	TOTALS		147,595	8,669	
C - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,402,288	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	43,229	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	138,000	3.00
	TOTALS		0	2,583,517	
D - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,667,183	1.00
	TOTALS		0	6,667,183	
E - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	56,333	1.00
	TOTALS		0	56,333	
F - UTILITIES EXPENSE					
1.00	NONPATIENT TELEPHONES	5.01	0	33,056	1.00
2.00	OPERATION OF PLANT	7.00	0	82,396	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
	TOTALS		0	115,452	
G - CHARGEABLE SUPPLIES					
1.00	PURCHASING, RECEIVING AND STORES	5.02	0	203,761	1.00
2.00	PHARMACY	15.00	0	328	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,970,638	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	TOTALS		0	15,174,727	
H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	6,065,853	1.00
	TOTALS		0	6,065,853	

Provider CCN: 150009

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

Worksheet A-6
Date/Time Prepared:
5/31/2013 8:07 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
I - SNF EXPENSES					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.01	0	1,231	1.00
	TOTALS		0	1,231	
500.00	Grand Total: Increases		147,595	30,789,482	500.00

RECLASSIFICATIONS

Provider CCN: 150009

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

Worksheet A-6
Date/Time Prepared:
5/31/2013 8:07 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - INTERNS & RESIDENTS						
1.00	MEDICAL RECORDS & LIBRARY	16.00		116,317	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05		200	0	2.00
	TOTALS		0	116,517		
B - NEW DIRECTIONS ADMIN						
1.00	SUBPROVIDER - IPF	40.00	147,595	8,669	0	1.00
	TOTALS		147,595	8,669		
C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,583,517	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	2,583,517		
D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	6,667,183	9	1.00
	TOTALS		0	6,667,183		
E - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	56,333	12	1.00
	TOTALS		0	56,333		
F - UTILITIES EXPENSE						
1.00	NONPATIENT TELEPHONES	5.01	0	42,590	0	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	47	0	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	8,305	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	36	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	40	0	5.00
6.00	OPERATING ROOM	50.00	0	1,042	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	63,392	0	7.00
	TOTALS		0	115,452		
G - CHARGEABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS	4.00	0	30,453	0	1.00
2.00	NONPATIENT TELEPHONES	5.01	0	152	0	2.00
3.00	ADMINISTRATIVE	5.03	0	391	0	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	2,522	0	4.00
5.00	OPERATION OF PLANT	7.00	0	299	0	5.00
6.00	LAUNDRY & LINEN SERVICE	8.00	0	12	0	6.00
7.00	HOUSEKEEPING	9.00	0	9,772	0	7.00
8.00	DIETARY	10.00	0	14,520	0	8.00
9.00	NURSING ADMINISTRATION	13.00	0	6	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	122,755	0	10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	423	0	11.00
12.00	SOCIAL SERVICE	17.00	0	1,670	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	632,746	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	0	462,556	0	14.00
15.00	SUBPROVIDER - IPF	40.00	0	15,148	0	15.00
16.00	NURSERY	43.00	0	97,590	0	16.00
17.00	SKILLED NURSING FACILITY	44.00	0	2,021	0	17.00
18.00	OPERATING ROOM	50.00	0	9,590,250	0	18.00
19.00	RECOVERY ROOM	51.00	0	485,301	0	19.00
20.00	DELIVERY ROOM & LABOR ROOM	52.00	0	44	0	20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,653,155	0	21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	57	0	22.00
23.00	LABORATORY	60.00	0	22,841	0	23.00
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,155,707	0	24.00
25.00	RESPIRATORY THERAPY	65.00	0	101,622	0	25.00
26.00	PHYSICAL THERAPY	66.00	0	13,137	0	26.00
27.00	ELECTROCARDIOLOGY	69.00	0	23,058	0	27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,340	0	28.00
29.00	EMERGENCY	91.00	0	675,817	0	29.00
30.00	SIRH	194.00	0	58,012	0	30.00
31.00	OTHER NONREIMBURSABLE COST CENTERS	194.01	0	350	0	31.00
	TOTALS		0	15,174,727		
H - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,065,853	0	1.00
	TOTALS		0	6,065,853		

RECLASSIFICATIONS

Provider CCN: 150009

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

Worksheet A-6
Date/Time Prepared:
5/31/2013 8:07 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
I - SNF EXPENSES							
1.00	SKILLED NURSING FACILITY	44.00	0	1,231	0	1.00	
TOTALS			0	1,231			
500.00	Grand Total: Decreases		147,595	30,789,482		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150009

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

Worksheet A-7
Part I
Date/Time Prepared:
5/31/2013 8:07 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,432,533	0	0	0	66,909 1.00
2.00	Land Improvements	1,545,186	0	0	0	0 2.00
3.00	Buildings and Fixtures	85,484,205	1,044,911	0	1,044,911	0 3.00
4.00	Building Improvements	0	4,134,642	0	4,134,642	0 4.00
5.00	Fixed Equipment	20,042,842	1,172,453	0	1,172,453	0 5.00
6.00	Movable Equipment	86,877,655	16,575,876	0	16,575,876	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	200,382,421	22,927,882	0	22,927,882	66,909 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	200,382,421	22,927,882	0	22,927,882	66,909 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,365,624	0			1.00
2.00	Land Improvements	1,545,186	0			2.00
3.00	Buildings and Fixtures	86,529,116	0			3.00
4.00	Building Improvements	4,134,642	0			4.00
5.00	Fixed Equipment	21,215,295	0			5.00
6.00	Movable Equipment	103,453,531	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	223,243,394	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	223,243,394	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150009

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

Worksheet A-7
Part II
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,532,477	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,532,477	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	12,835	10,545,312				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	12,835	10,545,312				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150009

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

Worksheet A-7
Part III
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	119,789,863	0	119,789,863	0.536589	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	103,453,531	0	103,453,531	0.463411	0	2.00
3.00	Total (sum of lines 1-2)	223,243,394	0	223,243,394	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,499,734	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	6,588,391	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,088,125	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,402,288	56,333	0	12,835	5,971,190	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	43,229	0	0	0	6,631,620	2.00
3.00	Total (sum of lines 1-2)	2,445,517	56,333	0	12,835	12,602,810	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-6,108	OPERATING ROOM	50.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-7,104	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00 Television and radio service (chapter 21)	A	-3,706	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,685,402			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-10,360			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-860,969	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-33,189	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0	*** Cost Center Deleted ***	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 AHA DUES - LOBBYING PORTION	A	-8,104	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.00

Provider CCN: 150009

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

Worksheet A-8

Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 NONALLOWABLE DEPRECIATION - BUILDING	A	-352,725	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 34.00
35.00 NONALLOWABLE DEPRECIATION - EQUIP	A	-67,982	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9 35.00
36.00 UTILITIES	A	-208,983	OPERATION OF PLANT	7.00	0 36.00
37.00 TAXI EXPENSE	A	-3,267	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 37.00
38.00 PENSION VALUATION	A	-1,433,917	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 38.00
39.00 ADVERTISING - PERSONNEL	A	-15,451	EMPLOYEE BENEFITS	4.00	0 39.00
40.00 ADVERTISING - A & G	A	-780,728	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 40.00
41.00 ADVERTISING - A&P	A	-1,855	ADULTS & PEDIATRICS	30.00	0 41.00
42.00 ADVERTISING - PSYCH	A	-3,959	SUBPROVIDER - IPF	40.00	0 42.00
43.00 ADVERTISING - RADIOLOGY	A	-5,228	RADIOLOGY-DIAGNOSTIC	54.00	0 43.00
44.00 GOODWILL AMORTIZATION	A	-12,835	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 44.00
45.00 PHYSICIAN RECRUITMENT	A	-174,061	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 45.00
46.00 DONATIONS	A	-130,229	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 46.00
47.00 INTEREST INCOME	B	-168,985	INTEREST EXPENSE	113.00	0 47.00
48.00 RENTAL INCOME	B	-37,227	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 48.00
49.00 MISCELLANEOUS INCOME - A & G	B	-636,179	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 49.00
49.01 SELF INSURANCE ADJUSTMENT	A	23,334	EMPLOYEE BENEFITS	4.00	0 49.01
49.02		0		0.00	0 49.02
49.03		0		0.00	0 49.03
49.04		0		0.00	0 49.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,625,219			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150009

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

Worksheet A-8-1

Date/Time Prepared: 5/31/2013 8:07 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	15.00	PHARMACY	PHARMACY	61,669	73,045 1.00
2.00	14.00	CENTRAL SERVICES & SUPPLY	MEDICAL SUPPLIES	124,243	132,777 2.00
3.00	60.00	LABORATORY	LAB	150,243	139,642 3.00
4.00	64.00	INTRAVENOUS THERAPY	IV THERAPY	38,282	21,801 4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	X-RAY	1,412	1,359 4.01
4.02	69.00	ELECTROCARDIOLOGY	EKG	17	17 4.02
4.03	91.00	EMERGENCY	EMERGENCY ROOM	493	485 4.03
4.04	50.00	OPERATING ROOM	MEDICAL RECORDS	103	73 4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	RESPIRATORY THERAPY	28,194	33,026 4.05
4.06	65.00	RESPIRATORY THERAPY	A&G	302,358	326,263 4.06
4.07	5.05	OTHER ADMINISTRATIVE AND GENERAL		11,114	0 4.07
5.00	0		0	718,128	728,488 5.00

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

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

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

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

6.00	C		0.00	SIRH	33.33	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150009

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2013 8:07 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-11,376	0		1.00
2.00	-8,534	0		2.00
3.00	10,601	0		3.00
4.00	16,481	0		4.00
4.01	53	0		4.01
4.02	0	0		4.02
4.03	8	0		4.03
4.04	30	0		4.04
4.05	-4,832	0		4.05
4.06	-23,905	0		4.06
4.07	11,114	0		4.07
5.00	-10,360			5.00

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

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

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

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

6.00	REHAB FACILITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150009

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2013 8:07 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	2,775	2,775	0	177,200	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	13,549	13,549	0	177,200	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	10,406	10,406	0	177,200	0	3.00
4.00	40.00	SUBPROVIDER - IPF	78,234	78,234	0	154,100	0	4.00
5.00	50.00	OPERATING ROOM	1,388,445	1,388,445	0	208,000	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	90,000	90,000	0	196,400	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	3,320	3,320	0	225,300	0	7.00
8.00	60.00	LABORATORY	83,443	83,443	0	215,700	0	8.00
9.00	65.00	RESPIRATORY THERAPY	140	140	0	177,200	0	9.00
10.00	91.00	EMERGENCY	15,090	15,090	0	177,200	0	10.00
200.00			1,685,402	1,685,402	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	2,775		1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	13,549		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	10,406		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	78,234		4.00
5.00	50.00	OPERATING ROOM	0	0	0	1,388,445		5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	90,000		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,320		7.00
8.00	60.00	LABORATORY	0	0	0	83,443		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	140		9.00
10.00	91.00	EMERGENCY	0	0	0	15,090		10.00
200.00			0	0	0	1,685,402		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009

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

Worksheet B Part I Date/Time Prepared: 5/31/2013 8:07 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	NONPATIENT TELEPHONES	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	5,971,190	5,971,190			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	6,631,620		6,631,620		2.00
4.00 00400	EMPLOYEE BENEFITS	13,953,685	0	0	13,953,685	4.00
5.01 00510	NONPATIENT TELEPHONES	582,141	0	0	69,928	652,069 5.01
5.02 00511	PURCHASING, RECEIVING AND STORES	932,843	31,096	34,535	150,037	9,742 5.02
5.03 00512	ADMITTING	1,467,839	229,440	254,817	320,727	9,093 5.03
5.04 00513	CASHIERING/ACCOUNTS RECEIVABLE	2,031,435	339,298	376,825	268,816	29,876 5.04
5.05 00560	OTHER ADMINISTRATIVE AND GENERAL	28,346,691	551,428	612,417	1,276,009	190,942 5.05
7.00 00700	OPERATION OF PLANT	6,491,904	918,139	1,019,687	288,832	18,185 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	978,039	0	0	30,955	1,299 8.00
9.00 00900	HOUSEKEEPING	1,920,983	0	0	387,616	0 9.00
10.00 01000	DIETARY	2,255,910	288,500	320,409	357,246	11,041 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	431,504	49,350	54,808	102,262	3,247 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	593,567	95,553	106,121	87,853	5,196 14.00
15.00 01500	PHARMACY	9,644,767	58,918	65,434	540,593	9,093 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,959,608	0	0	360,690	29,876 16.00
17.00 01700	SOCIAL SERVICE	2,328,087	0	0	424,410	11,041 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	116,517	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	11,849,985	1,198,658	1,331,236	2,745,475	53,257 30.00
31.00 03100	INTENSIVE CARE UNIT	4,275,559	115,995	128,824	976,614	17,536 31.00
40.00 04000	SUBPROVIDER - I/PF	918,626	257,200	285,647	215,864	6,495 40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	794,594	0	0	190,258	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,742,653	441,271	490,077	966,489	45,463 50.00
51.00 05100	RECOVERY ROOM	697,149	0	0	228,288	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,697,118	240,346	266,929	326,274	9,093 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,294,121	438,092	486,547	981,372	32,474 54.00
59.00 05900	CARDIAC CATHETERIZATION	6,966,501	100,715	111,854	266,063	13,639 59.00
60.00 06000	LABORATORY	6,144,817	180,153	200,078	677,985	23,381 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	127,999	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	618,292	0	0	53,837	1,948 64.00
65.00 06500	RESPIRATORY THERAPY	2,317,959	0	0	369,056	0 65.00
66.00 06600	PHYSICAL THERAPY	779,659	0	0	186,830	4,546 66.00
69.00 06900	ELECTROCARDIOLOGY	535,744	59,673	66,273	123,289	7,794 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	120,850	9,694	10,766	13,800	3,247 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,904,785	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	6,065,853	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	332,056	0	0	0	0 74.00
76.00 03021	DIABETES	0	0	0	0	0 76.00
76.01 03022	PARTIAL HOSPITALIZATION	134,158	0	0	30,675	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,953,456	319,139	354,437	841,022	33,123 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	154,910,264	5,922,658	6,577,721	13,859,165	580,627 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,841	14,261	0	2,598 190.00
194.00 07950	SIRH	268,679	0	0	62,008	0 194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	744,300	35,691	39,638	32,512	68,844 194.01
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	155,923,243	5,971,190	6,631,620	13,953,685	652,069 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009

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

Worksheet B Part I Date/Time Prepared: 5/31/2013 8:07 am

Cost Center Description		PURCHASING, RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 NONPATIENT TELEPHONES						5.01
5.02	00511 PURCHASING, RECEIVING AND STORES	1,158,253					5.02
5.03	00512 ADMINISTRATION	6,968	2,288,884				5.03
5.04	00513 CASHIERING/ACCOUNTS RECEIVABLE	0	0	3,046,250			5.04
5.05	00560 OTHER ADMINISTRATIVE AND GENERAL	1,013	0	0	30,978,500	30,978,500	5.05
7.00	00700 OPERATION OF PLANT	230	0	0	8,736,977	2,166,229	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	7,460	0	0	1,017,753	252,340	8.00
9.00	00900 HOUSEKEEPING	38,133	0	0	2,346,732	581,844	9.00
10.00	01000 DIETARY	4,898	0	0	3,238,004	802,824	10.00
11.00	01100 CAFETERIA	0	0	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	641,171	158,971	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	888,290	220,241	14.00
15.00	01500 PHARMACY	37,013	0	0	10,355,818	2,567,601	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	357	0	0	2,350,531	582,786	16.00
17.00	01700 SOCIAL SERVICE	2	0	0	2,763,540	685,187	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	116,517	28,889	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	95,078	142,132	189,171	17,604,992	4,364,895	30.00
31.00	03100 INTENSIVE CARE UNIT	53,280	50,695	67,472	5,685,975	1,409,769	31.00
40.00	04000 SUBPROVIDER - I/PF	3,215	11,987	15,954	1,714,988	425,211	40.00
41.00	04100 SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	3,278	7,034	9,362	1,004,526	249,060	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	79,181	166,769	221,962	8,153,865	2,021,653	50.00
51.00	05100 RECOVERY ROOM	5,690	35,547	47,311	1,013,985	251,405	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	27,811	15,231	20,271	2,603,073	645,401	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	17,168	497,353	661,808	8,408,935	2,084,895	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	86,934	115,705	7,661,411	1,899,555	59.00
60.00	06000 LABORATORY	668,143	249,294	331,798	8,475,649	2,101,435	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	48,615	95,665	127,326	399,605	99,077	63.00
64.00	06400 INTRAVENOUS THERAPY	7,753	44,932	59,803	786,565	195,019	64.00
65.00	06500 RESPIRATORY THERAPY	502	81,325	108,239	2,877,081	713,338	65.00
66.00	06600 PHYSICAL THERAPY	216	17,741	23,612	1,012,604	251,063	66.00
69.00	06900 ELECTROCARDIOLOGY	3,717	56,184	74,778	927,452	229,951	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,403	6,757	8,994	175,511	43,516	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	295,514	393,315	9,593,614	2,378,621	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	97,233	129,413	6,292,499	1,560,150	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	204,913	272,729	477,642	118,426	73.00
74.00	07400 RENAL DIALYSIS	0	2,188	2,913	337,157	83,594	74.00
76.00	03021 DIABETES	0	0	0	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	70	2,688	3,578	171,169	42,439	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	46,415	120,768	160,736	5,829,096	1,445,254	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,157,609	2,288,884	3,046,250	154,641,227	30,660,639	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	29,700	7,364	190.00
194.00	07950 SIRH	497	0	0	331,184	82,113	194.00
194.01	07951 OTHER NONREIMBURSABLE COST CENTERS	147	0	0	921,132	228,384	194.01
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,158,253	2,288,884	3,046,250	155,923,243	30,978,500	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	PURCHASING, RECEIVING AND STORES					5.02
5.03	00512	ADMITTING					5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT	10,903,206				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,270,093			8.00
9.00	00900	HOUSEKEEPING	0	0	2,928,576		9.00
10.00	01000	DIETARY	806,187	0	7,164	4,854,179	10.00
11.00	01100	CAFETERIA	0	0	0	3,348,338	11.00
13.00	01300	NURSING ADMINISTRATION	137,904	0	0	0	21,997
14.00	01400	CENTRAL SERVICES & SUPPLY	267,014	0	28,655	0	0
15.00	01500	PHARMACY	164,641	0	10,029	0	156,933
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6,447	0	145,786
17.00	01700	SOCIAL SERVICE	0	0	716	0	105,720
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,349,550	787,457	1,323,163	1,212,275	987,529
31.00	03100	INTENSIVE CARE UNIT	324,137	88,906	440,576	134,973	323,365
40.00	04000	SUBPROVIDER - I PF	718,722	50,804	146,859	129,389	77,487
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	716	0	46,264
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,233,093	165,112	334,551	0	262,221
51.00	05100	RECOVERY ROOM	0	0	22,924	3,243	61,584
52.00	05200	DELIVERY ROOM & LABOR ROOM	671,625	38,103	146,859	2,046	92,320
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,224,210	50,804	83,817	0	284,470
59.00	05900	CARDIAC CATHETERIZATION	281,438	12,701	35,819	0	62,995
60.00	06000	LABORATORY	503,422	0	57,311	0	215,888
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	716	0	11,700
65.00	06500	RESPIRATORY THERAPY	0	0	716	0	106,781
66.00	06600	PHYSICAL THERAPY	0	0	2,149	0	38,670
69.00	06900	ELECTROCARDIOLOGY	166,752	0	6,447	0	35,840
70.00	07000	ELECTROENCEPHALOGRAPHY	27,088	0	1,433	0	3,873
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03021	DIABETES	0	0	0	0	0
76.01	03022	PARTIAL HOSPITALIZATION	0	0	2,149	0	11,562
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	891,806	38,103	269,360	23,915	267,595
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,767,589	1,231,990	2,928,576	4,854,179	3,320,580
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,883	0	0	0	0
194.00	07950	SIRH	0	0	0	0	17,555
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	99,734	38,103	0	0	10,203
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	10,903,206	1,270,093	2,928,576	4,854,179	3,348,338

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	16A	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00560						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	960,043					13.00
14.00	01400	0	1,404,200				14.00
15.00	01500	0	0	13,255,022			15.00
16.00	01600	0	0	0	3,085,550		16.00
17.00	01700	0	0	0	0	3,555,163	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	145,406	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	432,304	0	0	825,205	30,887,370	30.00
31.00	03100	141,558	0	0	160	8,549,419	31.00
40.00	04000	33,921	0	0	50,774	3,348,155	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	20,253	0	0	0	1,320,819	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	114,791	0	0	391,300	12,676,586	50.00
51.00	05100	26,959	0	0	0	1,380,100	51.00
52.00	05200	40,415	0	0	12,333	4,252,175	52.00
54.00	05400	0	0	0	232,249	12,369,380	54.00
59.00	05900	27,577	0	0	0	9,981,496	59.00
60.00	06000	0	0	0	67,913	11,421,618	60.00
63.00	06300	0	0	0	0	498,682	63.00
64.00	06400	5,122	0	0	1,602	1,000,724	64.00
65.00	06500	0	0	0	0	3,697,916	65.00
66.00	06600	0	0	0	0	1,304,486	66.00
69.00	06900	0	0	0	24,026	1,390,468	69.00
70.00	07000	0	0	0	0	251,421	70.00
71.00	07100	0	828,478	0	0	12,800,713	71.00
72.00	07200	0	575,722	0	0	8,428,371	72.00
73.00	07300	0	0	13,255,022	0	13,851,090	73.00
74.00	07400	0	0	0	0	420,751	74.00
76.00	03021	0	0	0	0	0	76.00
76.01	03022	0	0	0	0	227,319	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	117,143	0	0	1,479,988	10,362,260	91.00
92.00	09200					0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		960,043	1,404,200	13,255,022	3,085,550	154,121,888	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	72,947	190.00
194.00	07950	0	0	0	0	430,852	194.00
194.01	07951	0	0	0	0	1,297,556	194.01
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		960,043	1,404,200	13,255,022	3,085,550	155,923,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009

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

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Part I
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Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		17.00	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.01 00510	NONPATIENT TELEPHONES					5.01
5.02 00511	PURCHASING, RECEIVING AND STORES					5.02
5.03 00512	ADMITTING					5.03
5.04 00513	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	3,555,163				17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,393	0	148,799		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	720,652	0	148,799	31,756,821	-148,799
31.00 03100	INTENSIVE CARE UNIT	199,484	0	0	8,748,903	0
40.00 04000	SUBPROVIDER - I PF	78,123	0	0	3,426,278	0
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	30,819	0	0	1,351,638	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	295,783	0	0	12,972,369	0
51.00 05100	RECOVERY ROOM	32,202	0	0	1,412,302	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	99,216	0	0	4,351,391	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	288,615	0	0	12,657,995	0
59.00 05900	CARDIAC CATHETERIZATION	232,898	0	0	10,214,394	0
60.00 06000	LABORATORY	266,501	0	0	11,688,119	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	11,636	0	0	510,318	0
64.00 06400	INTRAVENOUS THERAPY	23,350	0	0	1,024,074	0
65.00 06500	RESPIRATORY THERAPY	86,283	0	0	3,784,199	0
66.00 06600	PHYSICAL THERAPY	30,438	0	0	1,334,924	0
69.00 06900	ELECTROCARDIOLOGY	32,444	0	0	1,422,912	0
70.00 07000	ELECTROENCEPHALOGRAPHY	5,866	0	0	257,287	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	298,679	0	0	13,099,392	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	196,659	0	0	8,625,030	0
73.00 07300	DRUGS CHARGED TO PATIENTS	323,187	0	0	14,174,277	0
74.00 07400	RENAL DIALYSIS	9,817	0	0	430,568	0
76.00 03021	DIABETES	0	0	0	0	0
76.01 03022	PARTIAL HOSPITALIZATION	5,304	0	0	232,623	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	241,783	0	0	10,604,043	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,513,132	0	148,799	154,079,857	-148,799
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,702	0	0	74,649	0
194.00 07950	SIRH	10,053	0	0	440,905	0
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	30,276	0	0	1,327,832	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	3,555,163	0	148,799	155,923,243	-148,799

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009

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

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.01	00510 NONPATIENT TELEPHONES		5.01
5.02	00511 PURCHASING, RECEIVING AND STORES		5.02
5.03	00512 ADMITTING		5.03
5.04	00513 CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00560 OTHER ADMINISTRATIVE AND GENERAL		5.05
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	31,608,022	30.00
31.00	03100 INTENSIVE CARE UNIT	8,748,903	31.00
40.00	04000 SUBPROVIDER - I PF	3,426,278	40.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	1,351,638	43.00
44.00	04400 SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	12,972,369	50.00
51.00	05100 RECOVERY ROOM	1,412,302	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,351,391	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,657,995	54.00
59.00	05900 CARDIAC CATHETERIZATION	10,214,394	59.00
60.00	06000 LABORATORY	11,688,119	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	510,318	63.00
64.00	06400 INTRAVENOUS THERAPY	1,024,074	64.00
65.00	06500 RESPIRATORY THERAPY	3,784,199	65.00
66.00	06600 PHYSICAL THERAPY	1,334,924	66.00
69.00	06900 ELECTROCARDIOLOGY	1,422,912	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	257,287	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,099,392	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,625,030	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,174,277	73.00
74.00	07400 RENAL DIALYSIS	430,568	74.00
76.00	03021 DIABETES	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	232,623	76.01
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	10,604,043	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	153,931,058	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	74,649	190.00
194.00	07950 SIRH	440,905	194.00
194.01	07951 OTHER NONREIMBURSABLE COST CENTERS	1,327,832	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	155,774,444	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150009

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

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Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		NEW BLDG & FIXT	NEW MVBLE EQUIP		
		0	1.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.01 00510	NONPATIENT TELEPHONES	0	0	0	5.01
5.02 00511	PURCHASING, RECEIVING AND STORES	0	31,096	34,535	5.02
5.03 00512	ADMITTING	0	229,440	254,817	5.03
5.04 00513	CASHIERING/ACCOUNTS RECEIVABLE	0	339,298	376,825	5.04
5.05 00560	OTHER ADMINISTRATIVE AND GENERAL	0	551,428	612,417	5.05
7.00 00700	OPERATION OF PLANT	0	918,139	1,019,687	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	9.00
10.00 01000	DIETARY	0	288,500	320,409	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	49,350	54,808	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	95,553	106,121	14.00
15.00 01500	PHARMACY	0	58,918	65,434	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	1,198,658	1,331,236	30.00
31.00 03100	INTENSIVE CARE UNIT	0	115,995	128,824	31.00
40.00 04000	SUBPROVIDER - I PF	0	257,200	285,647	40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	441,271	490,077	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	240,346	266,929	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	438,092	486,547	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	100,715	111,854	59.00
60.00 06000	LABORATORY	0	180,153	200,078	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	59,673	66,273	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	9,694	10,766	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
76.00 03021	DIABETES	0	0	0	76.00
76.01 03022	PARTIAL HOSPITALIZATION	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00 09100	EMERGENCY	0	319,139	354,437	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			673,576	92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5,922,658	6,577,721	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,841	14,261	190.00
194.00 07950	SIRH	0	0	0	194.00
194.01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	35,691	39,638	194.01
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	5,971,190	6,631,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150009

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

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Part II
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Cost Center Description		NONPATIENT TELEPHONES	PURCHASING, RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES	0				5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	0	65,631			5.02
5.03	00512	ADMINITTING	0	395	484,652		5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	716,123	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	57	0	0	1,163,902
7.00	00700	OPERATION OF PLANT	0	13	0	0	81,385
8.00	00800	LAUNDRY & LINEN SERVICE	0	423	0	0	9,480
9.00	00900	HOUSEKEEPING	0	2,161	0	0	21,860
10.00	01000	DIETARY	0	278	0	0	30,162
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	5,973
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	8,274
15.00	01500	PHARMACY	0	2,097	0	0	96,464
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20	0	0	21,895
17.00	01700	SOCIAL SERVICE	0	0	0	0	25,742
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,085
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	5,388	30,104	44,475	164,034
31.00	03100	INTENSIVE CARE UNIT	0	3,019	10,737	15,863	52,965
40.00	04000	SUBPROVIDER - I/PF	0	182	2,539	3,751	15,975
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	186	1,490	2,201	9,357
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,487	35,322	52,184	75,953
51.00	05100	RECOVERY ROOM	0	322	7,529	11,123	9,445
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,576	3,226	4,766	24,248
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	973	105,201	155,534	78,329
59.00	05900	CARDIAC CATHETERIZATION	0	0	18,413	27,203	71,366
60.00	06000	LABORATORY	0	37,860	52,801	78,007	78,951
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,755	20,262	29,935	3,722
64.00	06400	INTRAVENOUS THERAPY	0	439	9,517	14,060	7,327
65.00	06500	RESPIRATORY THERAPY	0	28	17,225	25,447	26,800
66.00	06600	PHYSICAL THERAPY	0	12	3,758	5,551	9,432
69.00	06900	ELECTROCARDIOLOGY	0	211	11,900	17,581	8,639
70.00	07000	ELECTROENCEPHALOGRAPHY	0	79	1,431	2,114	1,635
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	62,590	92,469	89,365
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	20,594	30,425	58,615
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	43,401	64,119	4,449
74.00	07400	RENAL DIALYSIS	0	0	464	685	3,141
76.00	03021	DIABETES	0	0	0	0	0
76.01	03022	PARTIAL HOSPITALIZATION	0	4	569	841	1,594
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	2,630	25,579	37,789	54,298
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	65,595	484,652	716,123	1,151,960
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	277
194.00	07950	SIRH	0	28	0	0	3,085
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	8	0	0	8,580
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	65,631	484,652	716,123	1,163,902

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150009

Period:
From 01/01/2012
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	PURCHASING, RECEIVING AND STORES					5.02
5.03	00512	ADMITTING					5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT	2,019,224				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,903			8.00
9.00	00900	HOUSEKEEPING	0	0	24,021		9.00
10.00	01000	DIETARY	149,302	0	59	788,710	10.00
11.00	01100	CAFETERIA	0	0	0	544,040	11.00
13.00	01300	NURSING ADMINISTRATION	25,539	0	0	0	3,574
14.00	01400	CENTRAL SERVICES & SUPPLY	49,450	0	235	0	0
15.00	01500	PHARMACY	30,491	0	82	0	25,499
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	53	0	23,687
17.00	01700	SOCIAL SERVICE	0	0	6	0	17,177
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	620,322	6,141	10,851	196,971	160,455
31.00	03100	INTENSIVE CARE UNIT	60,029	693	3,614	21,931	52,541
40.00	04000	SUBPROVIDER - I PF	133,104	396	1,205	21,023	12,590
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	6	0	7,517
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	228,363	1,287	2,744	0	42,606
51.00	05100	RECOVERY ROOM	0	0	188	527	10,006
52.00	05200	DELIVERY ROOM & LABOR ROOM	124,382	297	1,205	332	15,000
54.00	05400	RADIOLOGY-DIAGNOSTIC	226,718	396	687	0	46,221
59.00	05900	CARDIAC CATHETERIZATION	52,121	99	294	0	10,235
60.00	06000	LABORATORY	93,231	0	470	0	35,078
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	6	0	1,901
65.00	06500	RESPIRATORY THERAPY	0	0	6	0	17,350
66.00	06600	PHYSICAL THERAPY	0	0	18	0	6,283
69.00	06900	ELECTROCARDIOLOGY	30,882	0	53	0	5,823
70.00	07000	ELECTROENCEPHALOGRAPHY	5,017	0	12	0	629
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03021	DIABETES	0	0	0	0	0
76.01	03022	PARTIAL HOSPITALIZATION	0	0	18	0	1,879
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	165,158	297	2,209	3,886	43,479
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,994,109	9,606	24,021	788,710	539,530
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,645	0	0	0	0
194.00	07950	SIRH	0	0	0	0	2,852
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	18,470	297	0	0	1,658
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,019,224	9,903	24,021	788,710	544,040

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150009

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

Worksheet B
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Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00560						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	139,244					13.00
14.00	01400	0	259,633				14.00
15.00	01500	0	0	278,985			15.00
16.00	01600	0	0	0	45,655		16.00
17.00	01700	0	0	0	0	42,925	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	41	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	62,702	0	0	12,210	8,666	30.00
31.00	03100	20,531	0	0	2	2,411	31.00
40.00	04000	4,920	0	0	751	944	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	2,937	0	0	0	372	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,649	0	0	5,790	3,575	50.00
51.00	05100	3,910	0	0	0	389	51.00
52.00	05200	5,862	0	0	182	1,199	52.00
54.00	05400	0	0	0	3,436	3,488	54.00
59.00	05900	4,000	0	0	0	2,815	59.00
60.00	06000	0	0	0	1,005	3,221	60.00
63.00	06300	0	0	0	0	141	63.00
64.00	06400	743	0	0	24	282	64.00
65.00	06500	0	0	0	0	1,043	65.00
66.00	06600	0	0	0	0	368	66.00
69.00	06900	0	0	0	355	392	69.00
70.00	07000	0	0	0	0	71	70.00
71.00	07100	0	153,183	0	0	3,610	71.00
72.00	07200	0	106,450	0	0	2,377	72.00
73.00	07300	0	0	278,985	0	3,906	73.00
74.00	07400	0	0	0	0	119	74.00
76.00	03021	0	0	0	0	0	76.00
76.01	03022	0	0	0	0	64	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	16,990	0	0	21,900	2,922	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		139,244	259,633	278,985	45,655	42,416	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	21	190.00
194.00	07950	0	0	0	0	122	194.00
194.01	07951	0	0	0	0	366	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		139,244	259,633	278,985	45,655	42,925	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150009

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	21.00	22.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS					4.00
5.01 00510 NONPATIENT TELEPHONES					5.01
5.02 00511 PURCHASING, RECEIVING AND STORES					5.02
5.03 00512 ADMITTING					5.03
5.04 00513 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00560 OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		1,126			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS			3,852,213	0	3,852,213
31.00 03100 INTENSIVE CARE UNIT			489,155	0	489,155
40.00 04000 SUBPROVIDER - I PF			740,227	0	740,227
41.00 04100 SUBPROVIDER - I RF			0	0	0
42.00 04200 SUBPROVIDER			0	0	0
43.00 04300 NURSERY			24,066	0	24,066
44.00 04400 SKILLED NURSING FACILITY			0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM			1,400,308	0	1,400,308
51.00 05100 RECOVERY ROOM			43,439	0	43,439
52.00 05200 DELIVERY ROOM & LABOR ROOM			689,550	0	689,550
54.00 05400 RADIOLOGY-DIAGNOSTIC			1,545,622	0	1,545,622
59.00 05900 CARDIAC CATHETERIZATION			399,115	0	399,115
60.00 06000 LABORATORY			760,855	0	760,855
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			56,815	0	56,815
64.00 06400 INTRAVENOUS THERAPY			34,299	0	34,299
65.00 06500 RESPIRATORY THERAPY			87,899	0	87,899
66.00 06600 PHYSICAL THERAPY			25,422	0	25,422
69.00 06900 ELECTROCARDIOLOGY			201,782	0	201,782
70.00 07000 ELECTROENCEPHALOGRAPHY			31,448	0	31,448
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			401,217	0	401,217
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			218,461	0	218,461
73.00 07300 DRUGS CHARGED TO PATIENTS			394,860	0	394,860
74.00 07400 RENAL DIALYSIS			4,409	0	4,409
76.00 03021 DIABETES			0	0	0
76.01 03022 PARTIAL HOSPITALIZATION			4,969	0	4,969
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY			1,050,713	0	1,050,713
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00		0	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			34,045	0	34,045
194.00 07950 SIRH			6,087	0	6,087
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS			104,708	0	104,708
200.00	0	1,126	1,126	0	200.00
201.00	0	0	0	0	201.00
202.00	0	1,126	12,602,810	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150009

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

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Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS					
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONES)	PURCHASING, RECEIVING AND STORES (SUPPLIES)	
	1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	379,445					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		379,445				2.00
4.00 00400 EMPLOYEE BENEFITS	0	0	57,448,819			4.00
5.01 00510 NONPATIENT TELEPHONES	0	0	287,899	1,004		5.01
5.02 00511 PURCHASING, RECEIVING AND STORES	1,976	1,976	617,718	15	3,010,364	5.02
5.03 00512 ADMITTING	14,580	14,580	1,320,468	14	18,111	5.03
5.04 00513 CASHIERING/ACCOUNTS RECEIVABLE	21,561	21,561	1,106,745	46	0	5.04
5.05 00560 OTHER ADMINISTRATIVE AND GENERAL	35,041	35,041	5,253,467	294	2,633	5.05
7.00 00700 OPERATION OF PLANT	58,344	58,344	1,189,151	28	597	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	127,446	2	19,390	8.00
9.00 00900 HOUSEKEEPING	0	0	1,595,856	0	99,109	9.00
10.00 01000 DIETARY	18,333	18,333	1,470,819	17	12,730	10.00
11.00 01100 CAFETERIA	0	0	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	3,136	3,136	421,025	5	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	6,072	6,072	361,702	8	0	14.00
15.00 01500 PHARMACY	3,744	3,744	2,225,681	14	96,198	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	1,484,998	46	929	16.00
17.00 01700 SOCIAL SERVICE	0	0	1,747,340	17	6	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	76,170	76,170	11,303,416	82	247,113	30.00
31.00 03100 INTENSIVE CARE UNIT	7,371	7,371	4,020,823	27	138,479	31.00
40.00 04000 SUBPROVIDER - IPF	16,344	16,344	888,734	10	8,357	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	783,313	0	8,520	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	28,041	28,041	3,979,139	70	205,796	50.00
51.00 05100 RECOVERY ROOM	0	0	939,888	0	14,789	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	15,273	15,273	1,343,303	14	72,283	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	27,839	27,839	4,040,415	50	44,620	54.00
59.00 05900 CARDIAC CATHETERIZATION	6,400	6,400	1,095,410	21	0	59.00
60.00 06000 LABORATORY	11,448	11,448	2,791,335	36	1,736,533	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	126,353	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	221,653	3	20,151	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	1,519,443	0	1,306	65.00
66.00 06600 PHYSICAL THERAPY	0	0	769,199	7	562	66.00
69.00 06900 ELECTROCARDIOLOGY	3,792	3,792	507,595	12	9,661	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	616	616	56,817	5	3,646	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03021 DIABETES	0	0	0	0	0	76.00
76.01 03022 PARTIAL HOSPITALIZATION	0	0	126,294	0	181	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	20,280	20,280	3,462,579	51	120,635	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00	376,361	376,361	57,059,671	894	3,008,688	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	816	816	0	4	0	190.00
194.00 07950 SIRH	0	0	255,294	0	1,293	194.00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	2,268	2,268	133,854	106	383	194.01
200.00						200.00
201.00						201.00
202.00	5,971,190	6,631,620	13,953,685	652,069	1,158,253	202.00
203.00	15.736642	17.477157	0.242889	649.471116	0.384755	203.00
204.00			0	0	65,631	204.00
205.00			0.000000	0.000000	0.021802	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150009

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00511	PURCHASING, RECEIVING AND STORES						5.02
5.03	00512	ADMITTING	430,156,713					5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE	0	430,156,713				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	-30,978,500	124,944,743		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	8,736,977	247,943	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,017,753	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,346,732	0	9.00
10.00	01000	DIETARY	0	0	0	3,238,004	18,333	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	641,171	3,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	888,290	6,072	14.00
15.00	01500	PHARMACY	0	0	0	10,355,818	3,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,350,531	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,763,540	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	116,517	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,711,459	26,711,459	0	17,604,992	76,170	30.00
31.00	03100	INTENSIVE CARE UNIT	9,527,252	9,527,252	0	5,685,975	7,371	31.00
40.00	04000	SUBPROVIDER - IPF	2,252,700	2,252,700	0	1,714,988	16,344	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,321,883	1,321,883	0	1,004,526	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,341,722	31,341,722	0	8,153,865	28,041	50.00
51.00	05100	RECOVERY ROOM	6,680,445	6,680,445	0	1,013,985	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,862,394	2,862,394	0	2,603,073	15,273	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,466,353	93,466,353	0	8,408,935	27,839	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,337,839	16,337,839	0	7,661,411	6,400	59.00
60.00	06000	LABORATORY	46,850,935	46,850,935	0	8,475,649	11,448	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	17,978,845	17,978,845	0	399,605	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,444,334	8,444,334	0	786,565	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,283,744	15,283,744	0	2,877,081	0	65.00
66.00	06600	PHYSICAL THERAPY	3,334,153	3,334,153	0	1,012,604	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,558,873	10,558,873	0	927,452	3,792	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,269,933	1,269,933	0	175,511	616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,537,233	55,537,233	0	9,593,614	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,273,533	18,273,533	0	6,292,499	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,510,161	38,510,161	0	477,642	0	73.00
74.00	07400	RENAL DIALYSIS	411,288	411,288	0	337,157	0	74.00
76.00	03021	DIABETES	0	0	0	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	505,240	505,240	0	171,169	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	22,696,394	22,696,394	0	5,829,096	20,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	430,156,713	430,156,713	-30,978,500	123,662,727	244,859	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	29,700	816	190.00
194.00	07950	SIRH	0	0	0	331,184	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	921,132	2,268	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,288,884	3,046,250		30,978,500	10,903,206	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005321	0.007082		0.247938	43.974647	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	484,652	716,123		1,163,902	2,019,224	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001127	0.001665		0.009315	8.143904	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150009

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

Worksheet B-1
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	PURCHASING, RECEIVING AND STORES					5.02
5.03	00512	ADMINISTRATIVE					5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,375,402				8.00
9.00	00900	HOUSEKEEPING	0	4,088			9.00
10.00	01000	DIETARY	0	10	640,590		10.00
11.00	01100	CAFETERIA	0	0	441,869	1,798,417	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,815	1,177,908
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40	0	0	14.00
15.00	01500	PHARMACY	0	14	0	84,290	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9	0	78,303	16.00
17.00	01700	SOCIAL SERVICE	0	1	0	56,783	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	852,750	1,847	159,980	530,408	530,408
31.00	03100	INTENSIVE CARE UNIT	96,278	615	17,812	173,682	173,682
40.00	04000	SUBPROVIDER - IPF	55,016	205	17,075	41,619	41,619
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	1	0	24,849	24,849
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	178,802	467	0	140,841	140,841
51.00	05100	RECOVERY ROOM	0	32	428	33,077	33,077
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,262	205	270	49,586	49,586
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,016	117	0	152,791	0
59.00	05900	CARDIAC CATHETERIZATION	13,754	50	0	33,835	33,835
60.00	06000	LABORATORY	0	80	0	115,955	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	1	0	6,284	6,284
65.00	06500	RESPIRATORY THERAPY	0	1	0	57,353	0
66.00	06600	PHYSICAL THERAPY	0	3	0	20,770	0
69.00	06900	ELECTROCARDIOLOGY	0	9	0	19,250	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2	0	2,080	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03021	DIABETES	0	0	0	0	0
76.01	03022	PARTIAL HOSPITALIZATION	0	3	0	6,210	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	41,262	376	3,156	143,727	143,727
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,334,140	4,088	640,590	1,783,508	1,177,908
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
194.00	07950	SIRH	0	0	0	9,429	0
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	41,262	0	0	5,480	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,270,093	2,928,576	4,854,179	3,348,338	960,043
203.00		Unit cost multiplier (Wkst. B, Part I)	0.923434	716.383562	7.577669	1.861825	0.815041
204.00		Cost to be allocated (per Wkst. B, Part II)	9,903	24,021	788,710	544,040	139,244
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007200	5.875978	1.231224	0.302510	0.118213

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150009

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

Worksheet B-1
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
		14.00	15.00	16.00	17A	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	PURCHASING, RECEIVING AND STORES					5.02
5.03	00512	ADMINISTRATIVE					5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100				14.00
15.00	01500	PHARMACY	0	1,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	19,264		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	-3,555,163	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	5,152	0	30,887,370
31.00	03100	INTENSIVE CARE UNIT	0	0	1	0	8,549,419
40.00	04000	SUBPROVIDER - IPF	0	0	317	0	3,348,155
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	1,320,819
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	2,443	0	12,676,586
51.00	05100	RECOVERY ROOM	0	0	0	0	1,380,100
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	77	0	4,252,175
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,450	0	12,369,380
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	9,981,496
60.00	06000	LABORATORY	0	0	424	0	11,421,618
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	498,682
64.00	06400	INTRAVENOUS THERAPY	0	0	10	0	1,000,724
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	3,697,916
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,304,486
69.00	06900	ELECTROCARDIOLOGY	0	0	150	0	1,390,468
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	251,421
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59	0	0	0	12,800,713
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	41	0	0	0	8,428,371
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,000	0	0	13,851,090
74.00	07400	RENAL DIALYSIS	0	0	0	0	420,751
76.00	03021	DIABETES	0	0	0	0	0
76.01	03022	PARTIAL HOSPITALIZATION	0	0	0	0	227,319
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	9,240	0	10,362,260
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	1,000	19,264	-3,555,163	150,566,725
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	72,947
194.00	07950	SIRH	0	0	0	0	430,852
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1,297,556
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,404,200	13,255,022	3,085,550		3,555,163
203.00		Unit cost multiplier (Wkst. B, Part I)	14,042.000000	13,255.022000	160.171823		0.023333
204.00		Cost to be allocated (per Wkst. B, Part II)	259,633	278,985	45,655		42,925
205.00		Unit cost multiplier (Wkst. B, Part II)	2,596.330000	278.985000	2.369965		0.000282

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150009

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

Worksheet B-1
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
		21.00	22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.01	00510	NONPATIENT TELEPHONES			5.01
5.02	00511	PURCHASING, RECEIVING AND STORES			5.02
5.03	00512	ADMITTING			5.03
5.04	00513	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	100	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03021	DIABETES	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	SIRH	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	148,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1,487.990000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,126	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	11.260000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 8:07 am

			Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	31,608,022		31,608,022	0	31,608,022	25,778,578	30.00
31.00	03100	INTENSIVE CARE UNIT	8,748,903		8,748,903	0	8,748,903	9,527,252	31.00
40.00	04000	SUBPROVIDER - I/PF	3,426,278		3,426,278	0	3,426,278	2,252,700	40.00
41.00	04100	SUBPROVIDER - I/RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	1,351,638		1,351,638	0	1,351,638	1,321,883	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	12,972,369		12,972,369	0	12,972,369	11,223,760	50.00
51.00	05100	RECOVERY ROOM	1,412,302		1,412,302	0	1,412,302	2,511,993	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,351,391		4,351,391	0	4,351,391	2,474,017	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,657,995		12,657,995	0	12,657,995	29,370,384	54.00
59.00	05900	CARDIAC CATHETERIZATION	10,214,394		10,214,394	0	10,214,394	11,565,284	59.00
60.00	06000	LABORATORY	11,688,119		11,688,119	0	11,688,119	27,790,478	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	510,318		510,318	0	510,318	11,556,192	63.00
64.00	06400	INTRAVENOUS THERAPY	1,024,074		1,024,074	0	1,024,074	3,387,690	64.00
65.00	06500	RESPIRATORY THERAPY	3,784,199	0	3,784,199	0	3,784,199	10,787,626	65.00
66.00	06600	PHYSICAL THERAPY	1,334,924	0	1,334,924	0	1,334,924	3,216,770	66.00
69.00	06900	ELECTROCARDIOLOGY	1,422,912		1,422,912	0	1,422,912	5,987,180	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	257,287		257,287	0	257,287	388,734	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,099,392		13,099,392	0	13,099,392	35,456,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,625,030		8,625,030	0	8,625,030	12,838,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,174,277		14,174,277	0	14,174,277	26,198,823	73.00
74.00	07400	RENAL DIALYSIS	430,568		430,568	0	430,568	409,863	74.00
76.00	03021	DIABETES	0		0	0	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	232,623		232,623	0	232,623	5,053	76.01
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	10,604,043		10,604,043	0	10,604,043	6,405,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,110,318		2,110,318	0	2,110,318	68,224	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	156,041,376	0	156,041,376	0	156,041,376	240,523,143	200.00
201.00		Less Observation Beds	2,110,318		2,110,318		2,110,318		201.00
202.00		Total (see instructions)	153,931,058	0	153,931,058	0	153,931,058	240,523,143	202.00
Charges									
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00					9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		25,778,578					30.00
31.00	03100	INTENSIVE CARE UNIT		9,527,252					31.00
40.00	04000	SUBPROVIDER - I/PF		2,252,700					40.00
41.00	04100	SUBPROVIDER - I/RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		1,321,883					43.00
44.00	04400	SKILLED NURSING FACILITY		0					44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	20,117,962	31,341,722	0.413901	0.000000	0.413901		50.00
51.00	05100	RECOVERY ROOM	4,168,452	6,680,445	0.211408	0.000000	0.211408		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	388,377	2,862,394	1.520193	0.000000	1.520193		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,095,969	93,466,353	0.135428	0.000000	0.135428		54.00
59.00	05900	CARDIAC CATHETERIZATION	4,772,555	16,337,839	0.625199	0.000000	0.625199		59.00
60.00	06000	LABORATORY	19,060,457	46,850,935	0.249475	0.000000	0.249475		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,422,653	17,978,845	0.028384	0.000000	0.028384		63.00
64.00	06400	INTRAVENOUS THERAPY	5,056,644	8,444,334	0.121274	0.000000	0.121274		64.00
65.00	06500	RESPIRATORY THERAPY	4,496,118	15,283,744	0.247596	0.000000	0.247596		65.00
66.00	06600	PHYSICAL THERAPY	117,383	3,334,153	0.400379	0.000000	0.400379		66.00
69.00	06900	ELECTROCARDIOLOGY	4,571,693	10,558,873	0.134760	0.000000	0.134760		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	881,199	1,269,933	0.202599	0.000000	0.202599		70.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital	
			Outpatient	Total (col. 6 + col. 7)				PPS	
			7.00	8.00				9.00	10.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,080,706	55,537,233	0.235867	0.000000	0.235867		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,435,157	18,273,533	0.471996	0.000000	0.471996		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,311,338	38,510,161	0.368066	0.000000	0.368066		73.00
74.00	07400	RENAL DIALYSIS	1,425	411,288	1.046877	0.000000	1.046877		74.00
76.00	03021	DIABETES	0	0	0.000000	0.000000	0.000000		76.00
76.01	03022	PARTIAL HOSPITALIZATION	500,187	505,240	0.460421	0.000000	0.460421		76.01
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	16,290,638	22,696,394	0.467213	0.000000	0.467213		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	864,657	932,881	2.262151	0.000000	2.262151		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	189,633,570	430,156,713					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	189,633,570	430,156,713					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 8:07 am

			Title XIX		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	31,608,022		31,608,022	0	31,608,022	25,778,578	30.00
31.00	03100	INTENSIVE CARE UNIT	8,748,903		8,748,903	0	8,748,903	9,527,252	31.00
40.00	04000	SUBPROVIDER - I/PF	3,426,278		3,426,278	0	3,426,278	2,252,700	40.00
41.00	04100	SUBPROVIDER - I/RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	1,351,638		1,351,638	0	1,351,638	1,321,883	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	12,972,369		12,972,369	0	12,972,369	11,223,760	50.00
51.00	05100	RECOVERY ROOM	1,412,302		1,412,302	0	1,412,302	2,511,993	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,351,391		4,351,391	0	4,351,391	2,474,017	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,657,995		12,657,995	0	12,657,995	29,370,384	54.00
59.00	05900	CARDIAC CATHETERIZATION	10,214,394		10,214,394	0	10,214,394	11,565,284	59.00
60.00	06000	LABORATORY	11,688,119		11,688,119	0	11,688,119	27,790,478	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	510,318		510,318	0	510,318	11,556,192	63.00
64.00	06400	INTRAVENOUS THERAPY	1,024,074		1,024,074	0	1,024,074	3,387,690	64.00
65.00	06500	RESPIRATORY THERAPY	3,784,199	0	3,784,199	0	3,784,199	10,787,626	65.00
66.00	06600	PHYSICAL THERAPY	1,334,924	0	1,334,924	0	1,334,924	3,216,770	66.00
69.00	06900	ELECTROCARDIOLOGY	1,422,912		1,422,912	0	1,422,912	5,987,180	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	257,287		257,287	0	257,287	388,734	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,099,392		13,099,392	0	13,099,392	35,456,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,625,030		8,625,030	0	8,625,030	12,838,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,174,277		14,174,277	0	14,174,277	26,198,823	73.00
74.00	07400	RENAL DIALYSIS	430,568		430,568	0	430,568	409,863	74.00
76.00	03021	DIABETES	0		0	0	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	232,623		232,623	0	232,623	5,053	76.01
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	10,604,043		10,604,043	0	10,604,043	6,405,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,110,318		2,110,318	0	2,110,318	68,224	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	156,041,376	0	156,041,376	0	156,041,376	240,523,143	200.00
201.00		Less Observation Beds	2,110,318		2,110,318		2,110,318		201.00
202.00		Total (see instructions)	153,931,058	0	153,931,058	0	153,931,058	240,523,143	202.00
Charges									
Cost Center Description	Outpatient		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	7.00	8.00					9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		25,778,578					30.00
31.00	03100	INTENSIVE CARE UNIT		9,527,252					31.00
40.00	04000	SUBPROVIDER - I/PF		2,252,700					40.00
41.00	04100	SUBPROVIDER - I/RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		1,321,883					43.00
44.00	04400	SKILLED NURSING FACILITY		0					44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	20,117,962	31,341,722	0.413901	0.000000	0.413901		50.00
51.00	05100	RECOVERY ROOM	4,168,452	6,680,445	0.211408	0.000000	0.211408		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	388,377	2,862,394	1.520193	0.000000	1.520193		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,095,969	93,466,353	0.135428	0.000000	0.135428		54.00
59.00	05900	CARDIAC CATHETERIZATION	4,772,555	16,337,839	0.625199	0.000000	0.625199		59.00
60.00	06000	LABORATORY	19,060,457	46,850,935	0.249475	0.000000	0.249475		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,422,653	17,978,845	0.028384	0.000000	0.028384		63.00
64.00	06400	INTRAVENOUS THERAPY	5,056,644	8,444,334	0.121274	0.000000	0.121274		64.00
65.00	06500	RESPIRATORY THERAPY	4,496,118	15,283,744	0.247596	0.000000	0.247596		65.00
66.00	06600	PHYSICAL THERAPY	117,383	3,334,153	0.400379	0.000000	0.400379		66.00
69.00	06900	ELECTROCARDIOLOGY	4,571,693	10,558,873	0.134760	0.000000	0.134760		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	881,199	1,269,933	0.202599	0.000000	0.202599		70.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Title XIX		Hospital		PPS	
			Outpatient	Total (col. 6 + col. 7)									
			7.00	8.00				9.00	10.00	11.00			
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,080,706	55,537,233	0.235867	0.000000	0.235867						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,435,157	18,273,533	0.471996	0.000000	0.471996						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,311,338	38,510,161	0.368066	0.000000	0.368066						73.00
74.00	07400	RENAL DIALYSIS	1,425	411,288	1.046877	0.000000	1.046877						74.00
76.00	03021	DIABETES	0	0	0.000000	0.000000	0.000000						76.00
76.01	03022	PARTIAL HOSPITALIZATION	500,187	505,240	0.460421	0.000000	0.460421						76.01
OUTPATIENT SERVICE COST CENTERS													
91.00	09100	EMERGENCY	16,290,638	22,696,394	0.467213	0.000000	0.467213						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	864,657	932,881	2.262151	0.000000	2.262151						92.00
SPECIAL PURPOSE COST CENTERS													
113.00	11300	INTEREST EXPENSE											113.00
200.00		Subtotal (see instructions)	189,633,570	430,156,713									200.00
201.00		Less Observation Beds											201.00
202.00		Total (see instructions)	189,633,570	430,156,713									202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150009

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

Worksheet C Part II Date/Time Prepared: 5/31/2013 8:07 am

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,972,369	1,400,308	11,572,061	0	0 50.00
51.00	05100	RECOVERY ROOM	1,412,302	43,439	1,368,863	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,351,391	689,550	3,661,841	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,657,995	1,545,622	11,112,373	0	0 54.00
59.00	05900	CARDIAC CATHETERIZATION	10,214,394	399,115	9,815,279	0	0 59.00
60.00	06000	LABORATORY	11,688,119	760,855	10,927,264	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	510,318	56,815	453,503	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	1,024,074	34,299	989,775	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	3,784,199	87,899	3,696,300	0	0 65.00
66.00	06600	PHYSICAL THERAPY	1,334,924	25,422	1,309,502	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	1,422,912	201,782	1,221,130	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	257,287	31,448	225,839	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,099,392	401,217	12,698,175	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,625,030	218,461	8,406,569	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,174,277	394,860	13,779,417	0	0 73.00
74.00	07400	RENAL DIALYSIS	430,568	4,409	426,159	0	0 74.00
76.00	03021	DIABETES	0	0	0	0	0 76.00
76.01	03022	PARTIAL HOSPITALIZATION	232,623	4,969	227,654	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	10,604,043	1,050,713	9,553,330	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,110,318	257,195	1,853,123	0	0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	110,906,535	7,608,378	103,298,157	0	0 200.00
201.00		Less Observation Beds	2,110,318	257,195	1,853,123	0	0 201.00
202.00		Total (line 200 minus line 201)	108,796,217	7,351,183	101,445,034	0	0 202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150009

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

Worksheet C Part II Date/Time Prepared: 5/31/2013 8:07 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	12,972,369	31,341,722	0.413901	50.00
51.00	05100 RECOVERY ROOM	1,412,302	6,680,445	0.211408	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,351,391	2,862,394	1.520193	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	12,657,995	93,466,353	0.135428	54.00
59.00	05900 CARDIAC CATHETERIZATION	10,214,394	16,337,839	0.625199	59.00
60.00	06000 LABORATORY	11,688,119	46,850,935	0.249475	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	510,318	17,978,845	0.028384	63.00
64.00	06400 INTRAVENOUS THERAPY	1,024,074	8,444,334	0.121274	64.00
65.00	06500 RESPIRATORY THERAPY	3,784,199	15,283,744	0.247596	65.00
66.00	06600 PHYSICAL THERAPY	1,334,924	3,334,153	0.400379	66.00
69.00	06900 ELECTROCARDIOLOGY	1,422,912	10,558,873	0.134760	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	257,287	1,269,933	0.202599	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,099,392	55,537,233	0.235867	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,625,030	18,273,533	0.471996	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,174,277	38,510,161	0.368066	73.00
74.00	07400 RENAL DIALYSIS	430,568	411,288	1.046877	74.00
76.00	03021 DIABETES	0	0	0.000000	76.00
76.01	03022 PARTIAL HOSPITALIZATION	232,623	505,240	0.460421	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	10,604,043	22,696,394	0.467213	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,110,318	932,881	2.262151	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	110,906,535	391,276,300		200.00
201.00	Less Observation Beds	2,110,318	0		201.00
202.00	Total (line 200 minus line 201)	108,796,217	391,276,300		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,852,213	0	3,852,213	45,982	83.78	30.00
31.00	INTENSIVE CARE UNIT	489,155		489,155	9,453	51.75	31.00
40.00	SUBPROVIDER - IPF	740,227	0	740,227	3,892	190.19	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	24,066		24,066	3,429	7.02	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	5,105,661		5,105,661	62,756		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	19,494	1,633,207				
31.00	INTENSIVE CARE UNIT	4,870	252,023				
40.00	SUBPROVIDER - IPF	3,289	625,535				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	27,653	2,510,765				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,400,308	31,341,722	0.044679	4,669,078	208,610	50.00
51.00	05100 RECOVERY ROOM	43,439	6,680,445	0.006502	978,100	6,360	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	689,550	2,862,394	0.240900	336,681	81,106	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,545,622	93,466,353	0.016537	15,042,169	248,752	54.00
59.00	05900 CARDIAC CATHETERIZATION	399,115	16,337,839	0.024429	4,161,426	101,659	59.00
60.00	06000 LABORATORY	760,855	46,850,935	0.016240	17,940,182	291,349	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	56,815	17,978,845	0.003160	1,072,846	3,390	63.00
64.00	06400 INTRAVENOUS THERAPY	34,299	8,444,334	0.004062	1,784,426	7,248	64.00
65.00	06500 RESPIRATORY THERAPY	87,899	15,283,744	0.005751	6,143,372	35,331	65.00
66.00	06600 PHYSICAL THERAPY	25,422	3,334,153	0.007625	1,748,327	13,331	66.00
69.00	06900 ELECTROCARDIOLOGY	201,782	10,558,873	0.019110	3,296,671	62,999	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	31,448	1,269,933	0.024764	203,907	5,050	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	401,217	55,537,233	0.007224	15,979,026	115,432	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,461	18,273,533	0.011955	6,634,926	79,321	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	394,860	38,510,161	0.010253	13,442,677	137,828	73.00
74.00	07400 RENAL DIALYSIS	4,409	411,288	0.010720	253,387	2,716	74.00
76.00	03021 DIABETES	0	0	0.000000	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	4,969	505,240	0.009835	4,108	40	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,050,713	22,696,394	0.046294	2,932,366	135,751	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	257,195	932,881	0.275700	26,935	7,426	92.00
200.00	Total (lines 50-199)	7,608,378	391,276,300		96,650,610	1,543,699	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description			Title XVIII		Hospital		PPS
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
200.00		Total (lines 30-199)	0	0	0	0	0 200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	45,982	0.00	19,494	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,453	0.00	4,870	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,892	0.00	3,289	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	3,429	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	62,756		27,653	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03021	DIABETES	0	0	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	31,341,722	0.000000	0.000000	4,669,078	50.00
51.00	05100 RECOVERY ROOM	0	6,680,445	0.000000	0.000000	978,100	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,862,394	0.000000	0.000000	336,681	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	93,466,353	0.000000	0.000000	15,042,169	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	16,337,839	0.000000	0.000000	4,161,426	59.00
60.00	06000 LABORATORY	0	46,850,935	0.000000	0.000000	17,940,182	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	17,978,845	0.000000	0.000000	1,072,846	63.00
64.00	06400 INTRAVENOUS THERAPY	0	8,444,334	0.000000	0.000000	1,784,426	64.00
65.00	06500 RESPIRATORY THERAPY	0	15,283,744	0.000000	0.000000	6,143,372	65.00
66.00	06600 PHYSICAL THERAPY	0	3,334,153	0.000000	0.000000	1,748,327	66.00
69.00	06900 ELECTROCARDIOLOGY	0	10,558,873	0.000000	0.000000	3,296,671	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,269,933	0.000000	0.000000	203,907	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,537,233	0.000000	0.000000	15,979,026	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	18,273,533	0.000000	0.000000	6,634,926	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	38,510,161	0.000000	0.000000	13,442,677	73.00
74.00	07400 RENAL DIALYSIS	0	411,288	0.000000	0.000000	253,387	74.00
76.00	03021 DIABETES	0	0	0.000000	0.000000	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	0	505,240	0.000000	0.000000	4,108	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	22,696,394	0.000000	0.000000	2,932,366	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	932,881	0.000000	0.000000	26,935	92.00
200.00	Total (lines 50-199)	0	391,276,300			96,650,610	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,507,177	0	50.00
51.00	05100 RECOVERY ROOM	0	995,411	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	13,446	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,709,755	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,159,073	0	59.00
60.00	06000 LABORATORY	0	517,829	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	333,326	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	1,209,078	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,483,310	0	65.00
66.00	06600 PHYSICAL THERAPY	0	43	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,779,822	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	236,063	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,199,341	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,117,224	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,115,203	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03021 DIABETES	0	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	0	126,846	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	2,882,489	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	254,763	0	92.00
200.00	Total (lines 50-199)	0	46,640,199	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 8:07 am
	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		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.413901	5,507,177	0	0	2,279,426	50.00
51.00	05100 RECOVERY ROOM	0.211408	995,411	0	0	210,438	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.520193	13,446	0	0	20,441	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135428	17,709,755	0	0	2,398,397	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.625199	2,159,073	0	0	1,349,850	59.00
60.00	06000 LABORATORY	0.249475	517,829	0	0	129,185	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.028384	333,326	0	0	9,461	63.00
64.00	06400 INTRAVENOUS THERAPY	0.121274	1,209,078	0	0	146,630	64.00
65.00	06500 RESPIRATORY THERAPY	0.247596	1,483,310	0	0	367,262	65.00
66.00	06600 PHYSICAL THERAPY	0.400379	43	0	0	17	66.00
69.00	06900 ELECTROCARDIOLOGY	0.134760	1,779,822	0	0	239,849	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.202599	236,063	0	0	47,826	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235867	5,199,341	3,267	0	1,226,353	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.471996	2,117,224	0	0	999,321	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.368066	4,115,203	28,796	0	1,514,666	73.00
74.00	07400 RENAL DIALYSIS	1.046877	0	0	0	0	74.00
76.00	03021 DIABETES	0.000000	0	0	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	0.460421	126,846	0	0	58,403	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.467213	2,882,489	0	0	1,346,736	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.262151	254,763	0	0	576,312	92.00
200.00	Subtotal (see instructions)		46,640,199	32,063	0	12,920,573	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		46,640,199	32,063	0	12,920,573	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 8:07 am
	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		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	771	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,599	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03021 DIABETES	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	11,370	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	11,370	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150009 Component CCN: 15S009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/31/2013 8:07 am		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,400,308	31,341,722	0.044679	3,335	149	50.00
51.00	05100	RECOVERY ROOM	43,439	6,680,445	0.006502	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	689,550	2,862,394	0.240900	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,545,622	93,466,353	0.016537	154,502	2,555	54.00
59.00	05900	CARDIAC CATHETERIZATION	399,115	16,337,839	0.024429	0	0	59.00
60.00	06000	LABORATORY	760,855	46,850,935	0.016240	498,780	8,100	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56,815	17,978,845	0.003160	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	34,299	8,444,334	0.004062	7,283	30	64.00
65.00	06500	RESPIRATORY THERAPY	87,899	15,283,744	0.005751	52,583	302	65.00
66.00	06600	PHYSICAL THERAPY	25,422	3,334,153	0.007625	90,457	690	66.00
69.00	06900	ELECTROCARDIOLOGY	201,782	10,558,873	0.019110	44,107	843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,448	1,269,933	0.024764	3,119	77	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	401,217	55,537,233	0.007224	307,731	2,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,461	18,273,533	0.011955	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,860	38,510,161	0.010253	669,060	6,860	73.00
74.00	07400	RENAL DIALYSIS	4,409	411,288	0.010720	13,600	146	74.00
76.00	03021	DIABETES	0	0	0.000000	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	4,969	505,240	0.009835	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,050,713	22,696,394	0.046294	71,134	3,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	932,881	0.000000	0	0	92.00
200.00		Total (lines 50-199)	7,351,183	391,276,300		1,915,691	25,268	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03021 DIABETES	0	0	0	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	31,341,722	0.000000	0.000000	3,335	50.00
51.00 05100 RECOVERY ROOM	0	6,680,445	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,862,394	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	93,466,353	0.000000	0.000000	154,502	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	16,337,839	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	46,850,935	0.000000	0.000000	498,780	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	17,978,845	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	8,444,334	0.000000	0.000000	7,283	64.00
65.00 06500 RESPIRATORY THERAPY	0	15,283,744	0.000000	0.000000	52,583	65.00
66.00 06600 PHYSICAL THERAPY	0	3,334,153	0.000000	0.000000	90,457	66.00
69.00 06900 ELECTROCARDIOLOGY	0	10,558,873	0.000000	0.000000	44,107	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,269,933	0.000000	0.000000	3,119	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,537,233	0.000000	0.000000	307,731	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	18,273,533	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	38,510,161	0.000000	0.000000	669,060	73.00
74.00 07400 RENAL DIALYSIS	0	411,288	0.000000	0.000000	13,600	74.00
76.00 03021 DIABETES	0	0	0.000000	0.000000	0	76.00
76.01 03022 PARTIAL HOSPITALIZATION	0	505,240	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	22,696,394	0.000000	0.000000	71,134	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	932,881	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	391,276,300			1,915,691	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
	Component CCN: 15S009	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	320	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,351	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	63	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.00 03021 DIABETES	0	0	0	76.00
76.01 03022 PARTIAL HOSPITALIZATION	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (Lines 50-199)	0	1,734	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 8:07 am
	Title XVIII	Subprovider - IPF	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.413901	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.211408	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.520193	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.135428	320	0	0	43	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.625199	0	0	0	0	59.00
60.00 06000 LABORATORY	0.249475	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.028384	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0.121274	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.247596	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.400379	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.134760	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.202599	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235867	1,351	0	0	319	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.471996	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.368066	63	0	0	23	73.00
74.00 07400 RENAL DIALYSIS	1.046877	0	0	0	0	74.00
76.00 03021 DIABETES	0.000000	0	0	0	0	76.00
76.01 03022 PARTIAL HOSPITALIZATION	0.460421	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0.467213	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.262151	0	0	0	0	92.00
200.00	Subtotal (see instructions)		1,734	0	385	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		1,734	0	385	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 8:07 am
	Title XVII I	Subprovider - IPF	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	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03021 DIABETES	0	0	76.00
76.01 03022 PARTIAL HOSPITALIZATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/31/2013 8:07 am
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,852,213	0	3,852,213	45,982	83.78	30.00
31.00	INTENSIVE CARE UNIT	489,155		489,155	9,453	51.75	31.00
40.00	SUBPROVIDER - IPF	740,227	0	740,227	3,892	190.19	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	24,066		24,066	3,429	7.02	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	5,105,661		5,105,661	62,756		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,835	321,296				
31.00	INTENSIVE CARE UNIT	845	43,729				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	306	2,148				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	4,986	367,173				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,400,308	31,341,722	0.044679	1,411,280	63,055	50.00
51.00	05100 RECOVERY ROOM	43,439	6,680,445	0.006502	145,046	943	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	689,550	2,862,394	0.240900	1,364,353	328,673	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,545,622	93,466,353	0.016537	2,140,930	35,405	54.00
59.00	05900 CARDIAC CATHETERIZATION	399,115	16,337,839	0.024429	0	0	59.00
60.00	06000 LABORATORY	760,855	46,850,935	0.016240	3,465,038	56,272	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	56,815	17,978,845	0.003160	88,614	280	63.00
64.00	06400 INTRAVENOUS THERAPY	34,299	8,444,334	0.004062	599,229	2,434	64.00
65.00	06500 RESPIRATORY THERAPY	87,899	15,283,744	0.005751	961,374	5,529	65.00
66.00	06600 PHYSICAL THERAPY	25,422	3,334,153	0.007625	99,438	758	66.00
69.00	06900 ELECTROCARDIOLOGY	201,782	10,558,873	0.019110	339,495	6,488	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	31,448	1,269,933	0.024764	31,792	787	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	401,217	55,537,233	0.007224	1,118,544	8,080	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,461	18,273,533	0.011955	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	394,860	38,510,161	0.010253	2,017,448	20,685	73.00
74.00	07400 RENAL DIALYSIS	4,409	411,288	0.010720	15,614	167	74.00
76.00	03021 DIABETES	0	0	0.000000	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	4,969	505,240	0.009835	290	3	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	1,050,713	22,696,394	0.046294	730,750	33,829	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	257,195	932,881	0.275700	0	0	92.00
200.00	Total (lines 50-199)	7,608,378	391,276,300		14,529,235	563,388	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Title XIX				Hospital	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	45,982	0.00	3,835	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,453	0.00	845	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,892	0.00	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	3,429	0.00	306	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	62,756		4,986	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description	Title XIX				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03021 DIABETES	0	0	0	0	0	76.00
76.01 03022 PARTIAL HOSPITALIZATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2013 8:07 am

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	31,341,722	0.000000	0.000000	1,411,280	50.00
51.00	05100	RECOVERY ROOM	0	6,680,445	0.000000	0.000000	145,046	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,862,394	0.000000	0.000000	1,364,353	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,466,353	0.000000	0.000000	2,140,930	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,337,839	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	46,850,935	0.000000	0.000000	3,465,038	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	17,978,845	0.000000	0.000000	88,614	63.00
64.00	06400	INTRAVENOUS THERAPY	0	8,444,334	0.000000	0.000000	599,229	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,283,744	0.000000	0.000000	961,374	65.00
66.00	06600	PHYSICAL THERAPY	0	3,334,153	0.000000	0.000000	99,438	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,558,873	0.000000	0.000000	339,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,269,933	0.000000	0.000000	31,792	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,537,233	0.000000	0.000000	1,118,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	18,273,533	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	38,510,161	0.000000	0.000000	2,017,448	73.00
74.00	07400	RENAL DIALYSIS	0	411,288	0.000000	0.000000	15,614	74.00
76.00	03021	DIABETES	0	0	0.000000	0.000000	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0	505,240	0.000000	0.000000	290	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	22,696,394	0.000000	0.000000	730,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	932,881	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	391,276,300			14,529,235	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/31/2013 8:07 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03021 DIABETES	0	0	0		76.00
76.01	03022 PARTIAL HOSPITALIZATION	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150009

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

Worksheet D
Part V
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.413901	0	1,784,114	0	50.00
51.00	05100	RECOVERY ROOM	0.211408	0	215,567	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.520193	0	173,320	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135428	0	3,243,252	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.625199	0	0	0	59.00
60.00	06000	LABORATORY	0.249475	0	2,009,430	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.028384	0	31,414	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.121274	0	140,823	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.247596	0	204,734	0	65.00
66.00	06600	PHYSICAL THERAPY	0.400379	0	3,250	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.134760	0	121,324	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202599	0	68,245	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235867	0	378,054	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.471996	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368066	0	434,383	0	73.00
74.00	07400	RENAL DIALYSIS	1.046877	0	0	0	74.00
76.00	03021	DIABETES	0.000000	0	0	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0.460421	0	63,912	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.467213	0	1,862,108	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262151	0	98,576	0	92.00
200.00		Subtotal (see instructions)		0	10,832,506	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,832,506	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/31/2013 8:07 am
		Title XIX	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		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	738,447	0	50.00
51.00	05100 RECOVERY ROOM	45,573	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	263,480	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	439,227	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	501,303	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	892	0	63.00
64.00	06400 INTRAVENOUS THERAPY	17,078	0	64.00
65.00	06500 RESPIRATORY THERAPY	50,691	0	65.00
66.00	06600 PHYSICAL THERAPY	1,301	0	66.00
69.00	06900 ELECTROCARDIOLOGY	16,350	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,826	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89,170	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	159,882	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03021 DIABETES	0	0	76.00
76.01	03022 PARTIAL HOSPITALIZATION	29,426	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	870,001	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	222,994	0	92.00
200.00	Subtotal (see instructions)	3,459,641	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,459,641	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/31/2013 8:07 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		45,982	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		45,982	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)		42,912	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)		19,494	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		31,608,022	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)		31,608,022	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		25,778,578	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		25,778,578	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.226135	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)		600.73	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)		31,608,022	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		687.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,400,176	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)		13,400,176	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/31/2013 8:07 am	
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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	8,748,903	9,453	925.52	4,870	4,507,282		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)					28,265,607		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					46,173,065		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,885,230		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,543,699		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,428,929		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					42,744,136		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					3,070		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					687.40		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,110,318		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 8:07 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,852,213	31,608,022	0.121875	2,110,318	257,195	90.00
91.00	Nursing School cost	0	31,608,022	0.000000	2,110,318	0	91.00
92.00	Allied health cost	0	31,608,022	0.000000	2,110,318	0	92.00
93.00	All other Medical Education	0	31,608,022	0.000000	2,110,318	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 15S009		Date/Time Prepared: 5/31/2013 8:07 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,892	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,892	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)		3,892	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,289	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,426,278	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)		3,426,278	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,252,700	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,252,700	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.520965	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)		578.80	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,426,278	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		880.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,895,438	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,895,438	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 15S009				Date/Time Prepared: 5/31/2013 8:07 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					569,747		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,465,185		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					625,535		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					25,268		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					650,803		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					2,814,382		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009 Component CCN: 15S009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 8:07 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	740,227	3,426,278	0.216044	0	0	90.00
91.00	Nursing School cost	0	3,426,278	0.000000	0	0	91.00
92.00	Allied health cost	0	3,426,278	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,426,278	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/31/2013 8:07 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		45,982	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		45,982	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)		42,912	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,835	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)		3,429	15.00
16.00	Nursery days (title V or XIX only)		306	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		31,608,022	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)		31,608,022	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		25,778,578	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		25,778,578	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.226135	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)		600.73	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)		31,608,022	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		687.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,636,179	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,636,179	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/31/2013 8:07 am
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00	NURSERY (title V & XIX only)	1,351,638	3,429	394.18	42.00
	Intensive Care Type Inpatient Hospital Units				
43.00	INTENSIVE CARE UNIT	8,748,903	9,453	925.52	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)				5,612,756
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				9,151,618
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				367,173
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				563,388
52.00	Total Program excludable cost (sum of lines 50 and 51)				930,561
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				8,221,057
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				0.00
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
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 III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				3,070
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				687.40
89.00	Observation bed cost (line 87 x line 88) (see instructions)				2,110,318

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/31/2013 8:07 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,852,213	31,608,022	0.121875	2,110,318	257,195	90.00
91.00	Nursing School cost	0	31,608,022	0.000000	2,110,318	0	91.00
92.00	Allied health cost	0	31,608,022	0.000000	2,110,318	0	92.00
93.00	All other Medical Education	0	31,608,022	0.000000	2,110,318	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/31/2013 8:07 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		14,063,320	30.00
31.00	03100	INTENSIVE CARE UNIT		3,195,230	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.413901	4,669,078	50.00
51.00	05100	RECOVERY ROOM	0.211408	978,100	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.520193	336,681	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135428	15,042,169	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.625199	4,161,426	59.00
60.00	06000	LABORATORY	0.249475	17,940,182	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.028384	1,072,846	63.00
64.00	06400	INTRAVENOUS THERAPY	0.121274	1,784,426	64.00
65.00	06500	RESPIRATORY THERAPY	0.247596	6,143,372	65.00
66.00	06600	PHYSICAL THERAPY	0.400379	1,748,327	66.00
69.00	06900	ELECTROCARDIOLOGY	0.134760	3,296,671	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202599	203,907	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235867	15,979,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.471996	6,634,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368066	13,442,677	73.00
74.00	07400	RENAL DIALYSIS	1.046877	253,387	74.00
76.00	03021	DIABETES	0.000000	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0.460421	4,108	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.467213	2,932,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262151	26,935	92.00
200.00		Total (sum of lines 50-94 and 96-98)		96,650,610	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		96,650,610	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15S009		Date/Time Prepared: 5/31/2013 8:07 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		1,897,250	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.413901	3,335	50.00
51.00	05100	RECOVERY ROOM	0.211408	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.520193	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135428	154,502	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.625199	0	59.00
60.00	06000	LABORATORY	0.249475	498,780	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.028384	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.121274	7,283	64.00
65.00	06500	RESPIRATORY THERAPY	0.247596	52,583	65.00
66.00	06600	PHYSICAL THERAPY	0.400379	90,457	66.00
69.00	06900	ELECTROCARDIOLOGY	0.134760	44,107	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202599	3,119	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235867	307,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.471996	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368066	669,060	73.00
74.00	07400	RENAL DIALYSIS	1.046877	13,600	74.00
76.00	03021	DIABETES	0.000000	0	76.00
76.01	03022	PARTIAL HOSPITALIZATION	0.460421	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.467213	71,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262151	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,915,691	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,915,691	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/31/2013 8:07 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,555,694	30.00
31.00	03100	INTENSIVE CARE UNIT		619,402	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		539,062	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.413901	1,411,280	584,130 50.00
51.00	05100	RECOVERY ROOM	0.211408	145,046	30,664 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.520193	1,364,353	2,074,080 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135428	2,140,930	289,942 54.00
59.00	05900	CARDIAC CATHETERIZATION	0.625199	0	0 59.00
60.00	06000	LABORATORY	0.249475	3,465,038	864,440 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.028384	88,614	2,515 63.00
64.00	06400	INTRAVENOUS THERAPY	0.121274	599,229	72,671 64.00
65.00	06500	RESPIRATORY THERAPY	0.247596	961,374	238,032 65.00
66.00	06600	PHYSICAL THERAPY	0.400379	99,438	39,813 66.00
69.00	06900	ELECTROCARDIOLOGY	0.134760	339,495	45,750 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202599	31,792	6,441 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235867	1,118,544	263,828 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.471996	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368066	2,017,448	742,554 73.00
74.00	07400	RENAL DIALYSIS	1.046877	15,614	16,346 74.00
76.00	03021	DIABETES	0.000000	0	0 76.00
76.01	03022	PARTIAL HOSPITALIZATION	0.460421	290	134 76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.467213	730,750	341,416 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262151	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		14,529,235	5,612,756 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		14,529,235	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/31/2013 8:07 am
		Title VIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		37,117,946	1.00
2.00	Outlier payments for discharges. (see instructions)		235,208	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		6,854,889	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		167.17	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		4.49	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.86	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		3.63	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.59	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		2.59	12.00
13.00	Total allowable FTE count for the prior year.		2.41	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		2.50	14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.50	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		2.50	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.014955	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.015088	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.014955	21.00
22.00	IME payment adjustment (see instructions)		357,983	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		357,983	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.07	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		17.33	31.00
32.00	Sum of lines 30 and 31		25.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.17	33.00
34.00	Disproportionate share adjustment (see instructions)		3,774,895	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		41,486,032	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		41,486,032	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,152,608	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		105,799	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/31/2013 8:07 am
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			44,744,439 59.00
60.00	Primary payer payments			189,264 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			44,555,175 61.00
62.00	Deductibles billed to program beneficiaries			4,185,995 62.00
63.00	Coinurance billed to program beneficiaries			173,075 63.00
64.00	Allowable bad debts (see instructions)			267,663 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			187,364 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,801 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			40,383,469 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-588 70.00
70.93	HVBP incentive payment (see instructions)			2,549 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-65,781 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			40,319,649 71.00
72.00	Interim payments			41,083,127 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			-763,478 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			348,909 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/31/2013 8:07 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,370	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,920,573	2.00
3.00	PPS payments		11,597,355	3.00
4.00	Outlier payment (see instructions)		4,588	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		11,370	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		32,063	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)		32,063	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		32,063	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		20,693	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)		11,370	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)		11,601,943	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		670	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,741,486	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)		8,871,157	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		27,612	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)		8,898,769	30.00
31.00	Primary payer payments		26,551	31.00
32.00	Subtotal (line 30 minus line 31)		8,872,218	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		223,878	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		156,715	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		201,018	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		9,028,933	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		9,028,933	40.00
41.00	Interim payments		9,269,820	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-240,887	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/31/2013 8:07 am
		Component CCN: 15S009	Title XVIII	Subprovider - IPF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		385	2.00
3.00	PPS payments		42	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		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)		42	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		8	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)		34	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)		34	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		34	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		34	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		34	40.00
41.00	Interim payments		33	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150009

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2013 8:07 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		41,083,127		9,269,820	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		41,083,127		9,269,820	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		763,478		240,887	6.02	
7.00	Total Medicare program liability (see instructions)		40,319,649		9,028,933	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150009
Component CCN: 15S009

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2013 8:07 am
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		2,321,250		33	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,321,250		33	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		10,487		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,331,737		34	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150009

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

Worksheet E-1
Part II
Date/Time Prepared:
5/31/2013 8:07 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			14,072 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			24,364 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			4,316 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			52,365 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			430,156,713 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			9,343,208 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			2,566,688 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			2,404,202 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			162,486 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/31/2013 8:07 am
		Component CCN: 15S009	Title XVII I	Subprovider - IPF PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,540,460	1.00
2.00	Net IPF PPS Outlier Payments		34,891	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		10.633880	9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.		0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,575,351	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition		0	14.00
15.00	Cost of teaching physicians (From Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,575,351	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,575,351	18.00
19.00	Deductibles		146,305	19.00
20.00	Subtotal (line 18 minus line 19)		2,429,046	20.00
21.00	Coinsurance		107,797	21.00
22.00	Subtotal (line 20 minus line 21)		2,321,249	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		14,983	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		10,488	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,947	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,331,737	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,331,737	31.00
32.00	Interim payments		2,321,250	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)		10,487	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		34,891	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E-4 Date/Time Prepared: 5/31/2013 8:07 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			4.49	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.86	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			3.63	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.59	6.00
7.00	Enter the lesser of line 5 or line 6			2.59	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	2.59	0.00	2.59	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	2.59	0.00	2.59	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	2.59	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	2.50	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.70	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.60	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	2.60	0.00		17.00
18.00	Per resident amount	91,802.31	0.00		18.00
19.00	Approved amount for resident costs	238,686	0	238,686	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			238,686	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	27,653	4,415		26.00
27.00	Total Inpatient Days (see instructions)	56,257	56,257		27.00
28.00	Ratio of inpatient days to total inpatient days	0.491548	0.078479		28.00
29.00	Program direct GME amount	117,326	18,732		29.00
30.00	Reduction for direct GME payments for Medicare managed care		2,647		30.00
31.00	Net Program direct GME amount			133,411	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet E-4 Date/Time Prepared: 5/31/2013 8:07 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		411,288	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		49,638,250	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		189,264	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		49,448,986	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		12,932,328	42.00
43.00	Primary payer payments (see instructions)		26,551	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		12,905,777	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		62,354,763	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.793027	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.206973	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		133,411	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		105,799	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		27,612	50.00

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

Provider CCN: 150009

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

Worksheet G

Date/Time Prepared:
5/31/2013 8:07 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,903,098	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,130,811	0	0	0	4.00
5.00	Other receivable	4,968,129	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,073,418	0	0	0	7.00
8.00	Prepaid expenses	1,272,604	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	33,349,408	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	61,697,468	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,365,624	0	0	0	12.00
13.00	Land improvements	1,545,186	0	0	0	13.00
14.00	Accumulated depreciation	-1,205,901	0	0	0	14.00
15.00	Buildings	86,529,116	0	0	0	15.00
16.00	Accumulated depreciation	-53,908,467	0	0	0	16.00
17.00	Leasehold improvements	4,134,642	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,215,295	0	0	0	19.00
20.00	Accumulated depreciation	-19,279,969	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	102,583,409	0	0	0	23.00
24.00	Accumulated depreciation	-65,843,878	0	0	0	24.00
25.00	Minor equipment depreciable	870,122	0	0	0	25.00
26.00	Accumulated depreciation	-131,847	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)	82,873,332	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	10,309,551	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	-21,544,049	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-11,234,498	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	133,336,302	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,946,330	0	0	0	37.00
38.00	Salaries, wages, and fees payable	566,659	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,125,746	0	0	0	43.00
44.00	Other current liabilities	23,957,220	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	36,595,955	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	51,715,866	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	473,807	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	52,189,673	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	88,785,628	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	44,550,674				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,550,674	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	133,336,302	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150009

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

Worksheet G-1

Date/Time Prepared:
5/31/2013 8:07 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		48,870,316		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-13,510,421			2.00
3.00	Total (sum of line 1 and line 2)		35,359,895		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		35,359,895		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35,359,895		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150009

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2013 8:07 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,614,538		27,614,538	1.00
2.00	SUBPROVIDER - IPF	2,253,291		2,253,291	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	29,867,829		29,867,829	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,034,708		10,034,708	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)	10,034,708		10,034,708	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,902,537		39,902,537	17.00
18.00	Ancillary services	175,386,457	160,278,409	335,664,866	18.00
19.00	Outpatient services	9,076,720	20,615,506	29,692,226	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	2,385,746	570,762	2,956,508	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	226,751,460	181,464,677	408,216,137	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		162,548,462		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		162,548,462		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150009

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

Worksheet G-3

Date/Time Prepared:
5/31/2013 8:07 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	408,216,137	1.00
2.00	Less contractual allowances and discounts on patients' accounts	259,084,860	2.00
3.00	Net patient revenues (line 1 minus line 2)	149,131,277	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	162,548,462	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-13,417,185	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	209,364	6.00
7.00	Income from investments	168,985	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	860,969	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	33,189	21.00
22.00	Rental of hospital space	302,611	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	-1,668,354	24.00
25.00	Total other income (sum of lines 6-24)	-93,236	25.00
26.00	Total (line 5 plus line 25)	-13,510,421	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-13,510,421	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 150009

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

Worksheet I-5

Date/Time Prepared:
5/31/2013 8:07 am

		1.00	
1.00	Total expenses related to care of program beneficiaries (see instructions)	0	1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)	0	2.00
3.00	Deductibles billed to Medicare (Part B) patients	0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients	0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	5.00
6.00			6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)	0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)	0	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)	0	11.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150009	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/31/2013 8:07 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,958,403	1.00
2.00	Capital DRG outlier payments		23,505	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		143.96	3.00
4.00	Number of interns & residents (see instructions)		2.50	4.00
5.00	Indirect medical education percentage (see instructions)		0.49	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		14,496	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		8.07	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		17.33	8.00
9.00	Sum of lines 7 and 8		25.40	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.28	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		156,204	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		3,152,608	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00