

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: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/28/2013 12:47 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/28/2013 Time: 12:47 pm	
	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 DEACONESS WOMEN'S HOSPITAL (150149) 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-792	11,366	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-792	11,366	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 12:44 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00			
1.00	Street: 4199 GATEWAY BLVD	PO Box:	Zip Code: 47630-		County: WARRICK				1.00
2.00	City: NEWBURGH	State: IN							2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	DEACONESS WOMEN'S HOSPITAL	150149	21780	1	05/03/2001	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									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
17.10	Hospital-Based (CORF) I									17.10
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)	6		21.00

22.00 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.						3	N	23.00	

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
1.00	2.00	3.00	4.00	5.00	6.00		

24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,197	35	89	151	7,324	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: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 12:44 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150149

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

Worksheet S-2
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 12:44 pm			
		1.00	2.00	3.00			
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00	
		1.00					
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N					80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N					85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
		V		XIX			
		1.00		2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y			90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	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.					109.00	
		1.00		2.00		3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				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:	244,318	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		
119.00	DO NOT USE THIS LINE				
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	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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		
		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		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		
		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		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		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
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150149			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/28/2013 12:44 pm	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/28/2013 12:44 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/09/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/28/2013 12:44 pm
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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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC		HENDERSON	
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL, INC			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 450-6856		ERIC.HENDERSON@DEACONESS.COM	

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/09/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	FINANCIAL ANALYST	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: 150149

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	50	18,300	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)		50	18,300	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,784	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		74	27,084	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF					0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0	0.00	0	17.00
18.00 SUBPROVIDER	42.00	0	0	0.00	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		74				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 Vi s i t s / Tri ps			Full Time Equivalents		
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	147	400	9,212			1.00
2.00 HMO	0	6,983				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	147	400	9,212			7.00
8.00 INTENSIVE CARE UNIT	0	638	6,489			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		422	6,267			13.00
14.00 Total (see instructions)	147	1,460	21,968	0.00	381.04	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						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						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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150149

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	381.04	27.00
28.00	Observation Bed Days		0	697			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		119	359			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
		11.00	12.00	13.00	14.00		15.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	45	184	3,657	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	45	184	3,657	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150149		Period: From 01/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/28/2013 12:44 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	21,146,600	0	21,146,600	777,766.00	27.19	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		267,445	0	267,445	1,716.00	155.85	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		1,340,843	0	1,340,843	6,360.00	210.82	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		710,974	0	710,974	32,616.00	21.80	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		0	0	0	0.00	0.00	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		140,939	0	140,939	799.00	176.39	13.00
14.00	Home office salaries & wage-related costs		1,066,460	0	1,066,460	35,952.00	29.66	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		5,323,882	0	5,323,882			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		222,233	0	222,233			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		29,188	0	29,188			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		127,609	0	127,609			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	175,843	0	175,843	6,292.00	27.95	26.00
27.00	Administrative & General	5.00	3,445,687	-33,333	3,412,354	98,925.00	34.49	27.00
28.00	Administrative & General under contract (see inst.)		294,241	0	294,241	1,052.00	279.70	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	412,739	0	412,739	24,405.00	16.91	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	554,355	0	554,355	46,274.00	11.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	98,361	98,361	7,672.00	12.82	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	499,565	-98,361	401,204	31,294.00	12.82	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	184,579	0	184,579	11,198.00	16.48	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150149

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

		Worksheet A Line Number	Amount Reported	Reclassifi- 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	
42.00	Social Service	17.00	206,413	0	206,413	8,332.00	24.77	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150149

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2013 12:44 pm

	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)	20,099,998	0	20,099,998	772,458.00	26.02	1.00
2.00	Excluded area salaries (see instructions)	710,974	0	710,974	32,616.00	21.80	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,389,024	0	19,389,024	739,842.00	26.21	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,207,399	0	1,207,399	36,751.00	32.85	4.00
5.00	Subtotal wage-related costs (see inst.)	5,353,070	0	5,353,070	0.00	27.61	5.00
6.00	Total (sum of lines 3 thru 5)	25,949,493	0	25,949,493	776,593.00	33.41	6.00
7.00	Total overhead cost (see instructions)	5,773,422	-33,333	5,740,089	235,444.00	24.38	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150149

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	408,415	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)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	8,415	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)	3,006,518	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	261,689	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,045	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)	277,362	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	90,355	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	1,452,156	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	110,349	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	18,380	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	36,226	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,702,910	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: 150149

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

Worksheet S-3
Part V
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/28/2013 12:44 pm
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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)		0.466727	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		10,104,449	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		867,219	5.00	
6.00	Medicaid charges		30,396,462	6.00	
7.00	Medicaid cost (line 1 times line 6)		14,186,850	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)		3,215,182	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)		3,215,182	19.00	
			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	152,511	75,234	227,745	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	71,181	35,114	106,295	21.00
22.00	Partial payment by patients approved for charity care	10,177	14,006	24,183	22.00
23.00	Cost of charity care (line 21 minus line 22)	61,004	21,108	82,112	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)		1,666,023	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		10,573	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,655,450	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		772,643	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		854,755	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,069,937	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150149

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

Worksheet A
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	3,500,392	3,500,392	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,709,251	1,709,251	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	175,843	5,723,569	5,899,412	-484	5,898,928	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,445,687	10,224,423	13,670,110	-3,799,402	9,870,708	5.00
7.00	00700	OPERATION OF PLANT	412,739	1,273,497	1,686,236	-61,991	1,624,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	517,163	517,163	-177	516,986	8.00
9.00	00900	HOUSEKEEPING	554,355	153,939	708,294	-3,217	705,077	9.00
10.00	01000	DIETARY	0	0	0	165,414	165,414	10.00
11.00	01100	CAFETERIA	499,565	363,477	863,042	-188,399	674,643	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184,579	144,573	329,152	-599	328,553	16.00
17.00	01700	SOCIAL SERVICE	206,413	14,856	221,269	-2,208	219,061	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,343,539	738,830	6,082,369	-3,278,543	2,803,826	30.00
31.00	03100	INTENSIVE CARE UNIT	2,550,893	1,909,374	4,460,267	-252,301	4,207,966	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	702,943	158,159	861,102	-134,330	726,772	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,526,404	5,361,749	7,888,153	-2,453,761	5,434,392	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,751,338	2,751,338	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,639	243,597	742,236	-114,719	627,517	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,814,817	1,814,817	-702	1,814,115	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	647,799	259,516	907,315	-131,241	776,074	65.00
66.00	06600	PHYSICAL THERAPY	0	766,900	766,900	-53,486	713,414	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,300	95,497	149,797	2,219,885	2,369,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	162,901	162,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,786,320	1,786,320	-67,791	1,718,529	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,643,619	699,717	2,343,336	-276,016	2,067,320	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	512,658	4,101	516,759	-1,388	515,371	90.03
91.00	09100	EMERGENCY	475,651	222,461	698,112	414,249	1,112,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,435,626	32,476,535	52,912,161	102,675	53,014,836	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,955	36,528	151,483	-20,400	131,083	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	337,596	411,147	748,743	-21,617	727,126	194.01
194.02	07952	MARKETING	0	463,466	463,466	-2,632	460,834	194.02
194.03	07953	REPRODUCTIVE MEDICINE	258,423	370,364	628,787	-58,026	570,761	194.03
200.00		TOTAL (SUM OF LINES 118-199)	21,146,600	33,758,040	54,904,640	0	54,904,640	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150149

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

Worksheet A
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-23,252	3,477,140	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	92,306	1,801,557	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-33,154	5,865,774	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-61,617	9,809,091	5.00
7.00	00700	OPERATION OF PLANT	0	1,624,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	516,986	8.00
9.00	00900	HOUSEKEEPING	0	705,077	9.00
10.00	01000	DIETARY	0	165,414	10.00
11.00	01100	CAFETERIA	-384,583	290,060	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	328,553	16.00
17.00	01700	SOCIAL SERVICE	-596	218,465	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,803,826	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,436,546	2,771,420	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	726,772	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,796,600	2,637,792	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,751,338	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,745	623,772	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-12,000	1,802,115	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	776,074	65.00
66.00	06600	PHYSICAL THERAPY	-202,075	511,339	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,369,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	162,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,718,529	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-1,213,176	854,144	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	0	515,371	90.03
91.00	09100	EMERGENCY	-478,081	634,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,553,119	46,461,717	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131,083	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	727,126	194.01
194.02	07952	MARKETING	0	460,834	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	570,761	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-6,553,119	48,351,521	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - LEASEHOLD IMPROVEMENTS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	70,546	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
TOTALS			0	70,546	
B - EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,059,668	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
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
TOTALS			0	1,059,668	
C - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,345	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	43,893	2.00
TOTALS			0	45,238	
D - EQUIPMENT LEASES					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	556,655	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
TOTALS			0	556,655	
E - BUILDING LEASES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,256,162	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS			0	3,256,162	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
F - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	24,262	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS			0	24,262	
G - MEDICAL SUPPLIES CHARGED					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,442,467	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
TOTALS			0	2,442,467	
H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	162,901	1.00
TOTALS			0	162,901	
I - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	40,564	1.00
TOTALS			0	40,564	
J - DIETARY					
1.00	DIETARY	10.00	98,361	0	1.00
2.00	DIETARY	10.00	0	67,053	2.00
TOTALS			98,361	67,053	
K - PROPERTY TAXES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	131,775	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	49,035	2.00
TOTALS			0	180,810	
L - DEFAULT					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	2,646,665	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	104,673	2.00
TOTALS			2,646,665	104,673	
M - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,632	1.00
TOTALS			0	2,632	
N - EMERGENCY					
1.00	EMERGENCY	91.00	386,369	0	1.00
2.00	EMERGENCY	91.00	0	23,180	2.00
TOTALS			386,369	23,180	
O - PHYSICIAN BONUS					
1.00	EMERGENCY	91.00	8,333	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	25,000	0	2.00
TOTALS			33,333	0	
500.00	Grand Total: Increases		3,164,728	8,036,811	500.00

RECLASSIFICATIONS

Provider CCN: 150149

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

Worksheet A-6
Date/Time Prepared:
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Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
A - LEASEHOLD IMPROVEMENTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,756	9	1.00	
2.00	OPERATION OF PLANT	7.00	0	17,648	9	2.00	
3.00	CAFETERIA	11.00	0	1,983	9	3.00	
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	83	9	4.00	
5.00	SOCIAL SERVICE	17.00	0	270	9	5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	233	9	6.00	
7.00	OPERATING ROOM	50.00	0	3,490	9	7.00	
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,420	9	8.00	
9.00	CLINIC	90.00	0	2,322	9	9.00	
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	548	9	10.00	
11.00	WOMEN'S RESOURCES	194.01	0	541	9	11.00	
12.00	REPRODUCTIVE MEDICINE	194.03	0	252	9	12.00	
	TOTALS		0	70,546			
B - EQUIPMENT DEPRECIATION							
1.00	EMPLOYEE BENEFITS	4.00	0	484	9	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	341,280	9	2.00	
3.00	OPERATION OF PLANT	7.00	0	44,343	9	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	177	9	4.00	
5.00	HOUSEKEEPING	9.00	0	3,217	9	5.00	
6.00	CAFETERIA	11.00	0	20,937	9	6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	516	9	7.00	
8.00	SOCIAL SERVICE	17.00	0	817	9	8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	115,955	9	9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	64,465	9	10.00	
11.00	NURSERY	43.00	0	14,885	9	11.00	
12.00	OPERATING ROOM	50.00	0	200,181	9	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	101,934	9	13.00	
14.00	LABORATORY	60.00	0	702	9	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	20,412	9	15.00	
16.00	PHYSICAL THERAPY	66.00	0	1,825	9	16.00	
17.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	59,681	9	17.00	
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,854	9	18.00	
19.00	CLINIC	90.00	0	45,071	9	19.00	
20.00	OUTPATIENT LACTATION SERVICES	90.03	0	1,347	9	20.00	
21.00	EMERGENCY	91.00	0	599	9	21.00	
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,195	9	22.00	
23.00	WOMEN'S RESOURCES	194.01	0	2,290	9	23.00	
24.00	REPRODUCTIVE MEDICINE	194.03	0	9,501	9	24.00	
	TOTALS		0	1,059,668			
C - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,238	11	1.00	
2.00		0.00	0	0	11	2.00	
	TOTALS		0	45,238			
D - EQUIPMENT LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	122,299	10	1.00	
2.00	CAFETERIA	11.00	0	65	10	2.00	
3.00	SOCIAL SERVICE	17.00	0	1,121	10	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	32,374	10	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	17,580	10	5.00	
6.00	OPERATING ROOM	50.00	0	161,453	10	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,583	10	7.00	
8.00	RESPIRATORY THERAPY	65.00	0	30,715	10	8.00	
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	79,552	10	9.00	
10.00	CLINIC	90.00	0	68,304	10	10.00	
11.00	EMERGENCY	91.00	0	3,034	10	11.00	
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,654	10	12.00	
13.00	WOMEN'S RESOURCES	194.01	0	18,786	10	13.00	
14.00	REPRODUCTIVE MEDICINE	194.03	0	6,135	10	14.00	
	TOTALS		0	556,655			
E - BUILDING LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,001,754	10	1.00	
2.00	PHYSICAL THERAPY	66.00	0	45,734	10	2.00	
3.00	CLINIC	90.00	0	156,533	10	3.00	
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,003	10	4.00	
5.00	REPRODUCTIVE MEDICINE	194.03	0	42,138	10	5.00	
	TOTALS		0	3,256,162			
F - DRUGS/IV SOLUTIONS							
1.00	ADULTS & PEDIATRICS	30.00	0	13,033	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	389	0	2.00	
3.00	NURSERY	43.00	0	887	0	3.00	
4.00	OPERATING ROOM	50.00	0	8,659	0	4.00	

RECLASSIFICATIONS

Provider CCN: 150149

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

Worksheet A-6

Date/Time Prepared:
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Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	86	0	5.00	
6.00	PHYSICAL THERAPY	66.00	0	203	0	6.00	
7.00	CLINIC	90.00	0	988	0	7.00	
8.00	OUTPATIENT LACTATION SERVICES	90.03	0	17	0	8.00	
	TOTALS		0	24,262			
G - MEDICAL SUPPLIES CHARGED							
1.00	ADULTS & PEDIATRICS	30.00	0	365,610	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	194,867	0	2.00	
3.00	NURSERY	43.00	0	118,558	0	3.00	
4.00	OPERATING ROOM	50.00	0	1,670,429	0	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	116	0	5.00	
6.00	RESPIRATORY THERAPY	65.00	0	80,114	0	6.00	
7.00	PHYSICAL THERAPY	66.00	0	5,724	0	7.00	
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,227	0	8.00	
9.00	CLINIC	90.00	0	2,798	0	9.00	
10.00	OUTPATIENT LACTATION SERVICES	90.03	0	24	0	10.00	
	TOTALS		0	2,442,467			
H - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	162,901	0	1.00	
	TOTALS		0	162,901			
I - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,564	12	1.00	
	TOTALS		0	40,564			
J - DIETARY							
1.00	CAFETERIA	11.00	98,361	0	0	1.00	
2.00	CAFETERIA	11.00	0	67,053	0	2.00	
	TOTALS		98,361	67,053			
K - PROPERTY TAXES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	180,810	13	1.00	
2.00		0.00	0	0	13	2.00	
	TOTALS		0	180,810			
L - DEFAULT							
1.00	ADULTS & PEDIATRICS	30.00	2,646,665	0	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	104,673	0	2.00	
	TOTALS		2,646,665	104,673			
M - ADVERTISING							
1.00	MARKETING	194.02	0	2,632	0	1.00	
	TOTALS		0	2,632			
N - EMERGENCY							
1.00	OPERATING ROOM	50.00	386,369	0	0	1.00	
2.00	OPERATING ROOM	50.00	0	23,180	0	2.00	
	TOTALS		386,369	23,180			
O - PHYSICIAN BONUS							
1.00	ADMINISTRATIVE & GENERAL	5.00	33,333	0	0	1.00	
2.00		0.00	0	0	0	2.00	
	TOTALS		33,333	0			
500.00	Grand Total: Decreases		3,164,728	8,036,811		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150149

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

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	1,222,167	126,922	0	126,922	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	12,037,927	1,398,370	0	1,398,370	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,260,094	1,525,292	0	1,525,292	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,260,094	1,525,292	0	1,525,292	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	1,349,089	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	12,614,885	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	13,963,974	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	13,963,974	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150149

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150149

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

Worksheet A-7
Part III
Date/Time Prepared:
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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	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	70,546	3,256,162	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,151,974	556,655	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,222,520	3,812,817	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-21,907	40,564	131,775	0	3,477,140	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	43,893	0	49,035	0	1,801,557	2.00
3.00	Total (sum of lines 1-2)	21,986	40,564	180,810	0	5,278,697	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150149

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

Worksheet A-8

Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-23,252	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00		2.00
3.00 Investment income - other (chapter 2)		0			0.00		3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00		4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-72	ADMINISTRATIVE & GENERAL		5.00		5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00		7.00
8.00 Television and radio service (chapter 21)		0			0.00		8.00
9.00 Parking lot (chapter 21)		0			0.00		9.00
10.00 Provider-based physician adjustment	A-8-2	-5,940,744					10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-15	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-202,075					12.00
13.00 Laundry and linen service		0			0.00		13.00
14.00 Cafeteria-employees and guests	B	-279,214	CAFETERIA		11.00		14.00
15.00 Rental of quarters to employee and others		0			0.00		15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00		16.00
17.00 Sale of drugs to other than patients		0			0.00		17.00
18.00 Sale of medical records and abstracts		0			0.00		18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		19.00
20.00 Vending machines	B	-8,907	CAFETERIA		11.00		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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			NEW CAP REL COSTS-BLDG & FIXT		1.00		26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00		27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00 Physicians' assistant		0			0.00		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		32.00
33.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00		33.00
34.00 COFFEE SHOP REVENUE	B	-96,462	CAFETERIA		11.00		34.00

Provider CCN: 150149

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 CLASS REVENUE	B	-19,178	EMPLOYEE BENEFITS	4.00	0	35.00
36.00 FITNESS CENTER REVENUE	B	-13,976	EMPLOYEE BENEFITS	4.00	0	36.00
37.00 GAIN / LOSS ON DISPOSAL OF ASSETS	A	92,321	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	37.00
38.00 AHA DUES	A	-4,214	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 IHA DUES	A	-690	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 PHYSICIAN RECRUITMENT	A	-56,641	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,553,119				50.00

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

Provider CCN: 150149

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

Worksheet A-8-1

Date/Time Prepared: 5/28/2013 12:44 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	FACILITY RENT	3,398,994	3,398,994 1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	EQUIPMENT LEASE	276,635	276,635 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	VARIOUS	322,687	322,687 3.00
4.00	7.00	OPERATION OF PLANT	VARIOUS	1,070,594	1,070,594 4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	VARIOUS	120,936	120,936 4.01
4.02	30.00	ADULTS & PEDIATRICS	VARIOUS	141	141 4.02
4.03	31.00	INTENSIVE CARE UNIT	VARIOUS	3,311	3,311 4.03
4.04	50.00	OPERATING ROOM	VARIOUS	87,849	87,849 4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS	231	231 4.05
4.06	60.00	LABORATORY	VARIOUS	168	168 4.06
4.07	66.00	PHYSICAL THERAPY	VARIOUS	1,628	1,628 4.07
4.08	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	VARIOUS	3,895	3,895 4.08
4.09	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS	772,359	772,359 4.09
4.10	90.00	CLINIC	VARIOUS	3,835	3,835 4.10
4.11	90.03	OUTPATIENT LACTATION SERVICES	VARIOUS	12,642	12,642 4.11
4.12	0.00			0	0 4.12
4.13	66.00	PHYSICAL THERAPY	THERAPY SERVICES	435,111	637,186 4.13
5.00	0			6,511,016	6,713,091 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	B		50.00	DEACONESS HOSPITAL	0.00	6.00
7.00	B		50.00	DEACONESS HOSPITAL	0.00	7.00
8.00	B		50.00	DEACONESS HOSPITAL	0.00	8.00
9.00	B		50.00	DEACONESS HOSPITAL	0.00	9.00
10.00	B		50.00	DEACONESS HOSPITAL	0.00	10.00
10.01	B		50.00	DEACONESS HOSPITAL	0.00	10.01
10.02	B		50.00	DEACONESS HOSPITAL	0.00	10.02
10.03	B		50.00	DEACONESS HOSPITAL	0.00	10.03
10.04	B		50.00	DEACONESS HOSPITAL	0.00	10.04
10.05	B		50.00	DEACONESS HOSPITAL	0.00	10.05
10.06	B		50.00	DEACONESS HOSPITAL	0.00	10.06
10.07	B		50.00	DEACONESS HOSPITAL	0.00	10.07
10.08	B		50.00	DEACONESS HOSPITAL	0.00	10.08
10.09	B		50.00	DEACONESS HOSPITAL	0.00	10.09
10.10	B		50.00	DEACONESS HOSPITAL	0.00	10.10
10.11			0.00		0.00	10.11
10.12	A		0.00	PROGRESSIVE HEA	51.00	10.12
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: 150149

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2013 12:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	10		1.00
2.00	0	10		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	-202,075	0		4.13
5.00	-202,075			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	HOSPITAL		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOSPITAL		9.00
10.00	HOSPITAL		10.00
10.01	HOSPITAL		10.01
10.02	HOSPITAL		10.02
10.03	HOSPITAL		10.03
10.04	HOSPITAL		10.04
10.05	HOSPITAL		10.05
10.06	HOSPITAL		10.06
10.07	HOSPITAL		10.07
10.08	HOSPITAL		10.08
10.09	HOSPITAL		10.09
10.10	HOSPITAL		10.10
10.11			10.11
10.12	THERAPY SERVICE		10.12
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: 150149

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2013 12:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.00	SOCIAL SERVICE	1,750	0	1,750	171,400	14	1.00
2.00	31.00	INTENSIVE CARE UNIT	1,501,233	1,362,044	139,189	171,400	785	2.00
3.00	50.00	OPERATING ROOM	2,796,600	2,796,600	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	3,745	3,745	0	0	0	4.00
5.00	60.00	LABORATORY	12,000	12,000	0	0	0	5.00
6.00	90.00	CLINIC	1,221,872	1,146,872	75,000	194,500	93	6.00
7.00	91.00	EMERGENCY	611,822	419,377	192,445	171,400	1,623	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,149,022	5,740,638	408,384		2,515	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	17.00	SOCIAL SERVICE	1,154	58	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	64,687	3,234	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	8,696	435	0	0	0	6.00
7.00	91.00	EMERGENCY	133,741	6,687	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			208,278	10,414	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	17.00	SOCIAL SERVICE	0	1,154	596	596	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	64,687	74,502	1,436,546	2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,796,600	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,745	4.00
5.00	60.00	LABORATORY	0	0	0	12,000	5.00
6.00	90.00	CLINIC	0	8,696	66,304	1,213,176	6.00
7.00	91.00	EMERGENCY	0	133,741	58,704	478,081	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	208,278	200,106	5,940,744	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150149

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	3,477,140	3,477,140			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,801,557		1,801,557		2.00
4.00 00400	EMPLOYEE BENEFITS	5,865,774	60,830	539	5,927,143	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,809,091	740,507	516,707	964,472	5.00
7.00 00700	OPERATION OF PLANT	1,624,245	111,676	49,425	116,656	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	516,986	0	197	0	8.00
9.00 00900	HOUSEKEEPING	705,077	18,207	3,586	156,682	9.00
10.00 01000	DIETARY	165,414	154,886	0	27,801	10.00
11.00 01100	CAFETERIA	290,060	0	23,409	113,395	11.00
16.00 01600	MEDICAL RECORDS & LIBRARY	328,553	13,816	575	52,169	16.00
17.00 01700	SOCIAL SERVICE	218,465	3,272	2,160	58,340	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,803,826	1,052,937	165,328	762,239	30.00
31.00 03100	INTENSIVE CARE UNIT	2,771,420	175,834	91,447	728,045	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
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	726,772	95,371	16,591	198,678	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,637,792	422,288	403,078	604,855	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,751,338	0	0	748,048	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	623,772	10,320	127,641	140,934	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,802,115	4,615	782	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	776,074	0	56,986	183,093	65.00
66.00 06600	PHYSICAL THERAPY	511,339	65,725	2,034	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,369,682	21,703	66,520	15,347	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	162,901	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,718,529	25,031	90,735	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	854,144	293,076	126,368	464,549	90.00
90.03 09001	OUTPATIENT LACTATION SERVICES	515,371	4,671	1,501	144,897	90.03
91.00 09100	EMERGENCY	634,280	46,734	4,048	245,995	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,461,717	3,321,499	1,749,657	5,726,195	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	131,083	0	10,979	32,491	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	51,041	0	0	194.00
194.01 07951	WOMEN'S RESOURCES	727,126	32,247	23,492	95,417	194.01
194.02 07952	MARKETING	460,834	0	0	0	194.02
194.03 07953	REPRODUCTIVE MEDICINE	570,761	72,353	17,429	73,040	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	48,351,521	3,477,140	1,801,557	5,927,143	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150149

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,030,777				5.00
7.00	00700	OPERATION OF PLANT	630,013	2,532,015			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	171,310	0	688,493		8.00
9.00	00900	HOUSEKEEPING	292,665	17,979	0	1,194,196	9.00
10.00	01000	DIETARY	115,304	152,947	0	72,651	689,003
11.00	01100	CAFETERIA	141,393	0	0	0	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,876	13,643	0	6,481	16.00
17.00	01700	SOCIAL SERVICE	93,487	3,231	0	1,535	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,584,751	1,039,751	95,305	493,893	689,003
31.00	03100	INTENSIVE CARE UNIT	1,247,686	173,632	134,197	82,477	0
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	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	343,629	94,176	50,798	44,735	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,347,476	416,999	268,210	198,079	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,159,126	0	104,591	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,997	10,191	0	4,841	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	598,715	4,557	0	2,165	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	336,587	0	0	0	0
66.00	06600	PHYSICAL THERAPY	191,819	64,902	0	30,829	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	819,233	21,431	0	10,180	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,959	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	607,586	24,718	0	11,741	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	575,735	289,405	0	137,471	0
90.03	09001	OUTPATIENT LACTATION SERVICES	220,750	4,612	0	2,191	0
91.00	09100	EMERGENCY	308,401	46,149	35,392	21,921	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,269,498	2,378,323	688,493	1,121,190	689,003
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	57,818	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	16,907	50,402	0	23,942	0
194.01	07951	WOMEN'S RESOURCES	290,919	31,843	0	15,126	0
194.02	07952	MARKETING	152,645	0	0	0	0
194.03	07953	REPRODUCTIVE MEDICINE	242,990	71,447	0	33,938	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	12,030,777	2,532,015	688,493	1,194,196	689,003

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150149

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		CAFETERIA	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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
16.00	01600	568,257	11,248	557,361			16.00
17.00	01700		8,332	0	388,822		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	105,405	47,872	166,678	9,006,988	0	30.00
31.00	03100	88,946	58,281	113,005	5,664,970	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	32,287	22,061	109,139	1,734,237	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	81,447	116,450	0	6,496,674	0	50.00
52.00	05200	99,987	45,424	0	4,908,514	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	17,706	22,380	0	1,256,782	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	57,772	0	2,470,721	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	23,330	27,336	0	1,403,406	0	65.00
66.00	06600	0	9,508	0	876,156	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	3,749	55,990	0	3,383,835	0	71.00
72.00	07200	0	1,716	0	218,576	0	72.00
73.00	07300	0	60,292	0	2,538,632	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	26,455	15,210	0	2,782,413	0	90.00
90.03	09001	17,081	1,699	0	912,773	0	90.03
91.00	09100	19,789	15,370	0	1,378,079	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		535,762	557,361	388,822	45,032,756	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	3,958	0	0	236,329	0	192.00
194.00	07950	0	0	0	142,292	0	194.00
194.01	07951	17,289	0	0	1,233,459	0	194.01
194.02	07952	0	0	0	613,479	0	194.02
194.03	07953	11,248	0	0	1,093,206	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		568,257	557,361	388,822	48,351,521	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150149

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

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
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	9,006,988	30.00
31.00	03100 INTENSIVE CARE UNIT	5,664,970	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	1,734,237	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	6,496,674	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,908,514	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,256,782	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	2,470,721	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	1,403,406	65.00
66.00	06600 PHYSICAL THERAPY	876,156	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,383,835	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,576	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,538,632	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	2,782,413	90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	912,773	90.03
91.00	09100 EMERGENCY	1,378,079	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	45,032,756	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	236,329	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	142,292	194.00
194.01	07951 WOMEN'S RESOURCES	1,233,459	194.01
194.02	07952 MARKETING	613,479	194.02
194.03	07953 REPRODUCTIVE MEDICINE	1,093,206	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	48,351,521	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150149

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	60,830	539	61,369	61,369 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	740,507	516,707	1,257,214	9,993 5.00
7.00 00700	OPERATION OF PLANT	0	111,676	49,425	161,101	1,208 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	197	197	0 8.00
9.00 00900	HOUSEKEEPING	0	18,207	3,586	21,793	1,622 9.00
10.00 01000	DIETARY	0	154,886	0	154,886	288 10.00
11.00 01100	CAFETERIA	0	0	23,409	23,409	1,174 11.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	13,816	575	14,391	540 16.00
17.00 01700	SOCIAL SERVICE	0	3,272	2,160	5,432	604 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,052,937	165,328	1,218,265	7,891 30.00
31.00 03100	INTENSIVE CARE UNIT	0	175,834	91,447	267,281	7,537 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
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	95,371	16,591	111,962	2,057 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	422,288	403,078	825,366	6,262 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	7,744 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	10,320	127,641	137,961	1,459 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	4,615	782	5,397	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	0	56,986	56,986	1,895 65.00
66.00 06600	PHYSICAL THERAPY	0	65,725	2,034	67,759	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,703	66,520	88,223	159 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	25,031	90,735	115,766	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	293,076	126,368	419,444	4,809 90.00
90.03 09001	OUTPATIENT LACTATION SERVICES	0	4,671	1,501	6,172	1,500 90.03
91.00 09100	EMERGENCY	0	46,734	4,048	50,782	2,547 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,321,499	1,749,657	5,071,156	59,289 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,979	10,979	336 192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	51,041	0	51,041	0 194.00
194.01 07951	WOMEN'S RESOURCES	0	32,247	23,492	55,739	988 194.01
194.02 07952	MARKETING	0	0	0	0	0 194.02
194.03 07953	REPRODUCTIVE MEDICINE	0	72,353	17,429	89,782	756 194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	3,477,140	1,801,557	5,278,697	61,369 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150149

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	1,267,207					5.00
7.00	00700	66,359	228,668				7.00
8.00	00800	18,044		18,241			8.00
9.00	00900	30,826	1,624	0	55,865		9.00
10.00	01000	12,145	13,813	0	3,399	184,531	10.00
11.00	01100	14,893	0	0	0	0	11.00
16.00	01600	13,785	1,232	0	303	0	16.00
17.00	01700	9,847	292	0	72	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	166,934	93,901	2,522	23,106	184,531	30.00
31.00	03100	131,418	15,681	3,551	3,858	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	36,194	8,505	1,344	2,093	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	141,929	37,659	7,119	9,266	0	50.00
52.00	05200	122,090	0	2,768	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	31,493	920	0	226	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	63,062	412	0	101	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	35,453	0	0	0	0	65.00
66.00	06600	20,204	5,861	0	1,442	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	86,289	1,935	0	476	0	71.00
72.00	07200	5,683	0	0	0	0	72.00
73.00	07300	63,997	2,232	0	549	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	60,642	26,136	0	6,431	0	90.00
90.03	09001	23,251	417	0	102	0	90.03
91.00	09100	32,484	4,168	937	1,025	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		1,187,022	214,788	18,241	52,449	184,531	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	6,090	0	0	0	0	192.00
194.00	07950	1,781	4,552	0	1,120	0	194.00
194.01	07951	30,642	2,876	0	708	0	194.01
194.02	07952	16,078	0	0	0	0	194.02
194.03	07953	25,594	6,452	0	1,588	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,267,207	228,668	18,241	55,865	184,531	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150149

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		CAFETERIA	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	39,476					11.00
16.00	01600	781	31,032				16.00
17.00	01700	579	0	16,826			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,322	2,668	7,213	1,714,353	0	30.00
31.00	03100	6,179	3,248	4,890	443,643	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	2,243	1,230	4,723	170,351	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,658	6,455	0	1,039,714	0	50.00
52.00	05200	6,946	2,532	0	142,080	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,230	1,247	0	174,536	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	3,220	0	72,192	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,621	1,524	0	97,479	0	65.00
66.00	06600	0	530	0	95,796	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	260	3,121	0	180,463	0	71.00
72.00	07200	0	96	0	5,779	0	72.00
73.00	07300	0	3,361	0	185,905	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,838	848	0	520,148	0	90.00
90.03	09001	1,187	95	0	32,724	0	90.03
91.00	09100	1,375	857	0	94,175	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		37,219	31,032	16,826	4,969,338	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	275	0	0	17,680	0	192.00
194.00	07950	0	0	0	58,494	0	194.00
194.01	07951	1,201	0	0	92,154	0	194.01
194.02	07952	0	0	0	16,078	0	194.02
194.03	07953	781	0	0	124,953	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		39,476	31,032	16,826	5,278,697	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150149

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

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
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	1,714,353	30.00
31.00	03100 INTENSIVE CARE UNIT	443,643	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	170,351	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,039,714	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	142,080	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	174,536	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	72,192	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,479	65.00
66.00	06600 PHYSICAL THERAPY	95,796	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	180,463	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,779	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,905	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	520,148	90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	32,724	90.03
91.00	09100 EMERGENCY	94,175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,969,338	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	17,680	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	58,494	194.00
194.01	07951 WOMEN'S RESOURCES	92,154	194.01
194.02	07952 MARKETING	16,078	194.02
194.03	07953 REPRODUCTIVE MEDICINE	124,953	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	5,278,697	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150149

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

Worksheet B-1
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	124,326					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		1,616,327				2.00
4.00 00400	EMPLOYEE BENEFITS	2,175	484	20,970,757			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,477	463,579	3,412,354	-12,030,777	36,320,744	5.00
7.00 00700	OPERATION OF PLANT	3,993	44,343	412,739	0	1,902,002	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	177	0	0	517,183	8.00
9.00 00900	HOUSEKEEPING	651	3,217	554,355	0	883,552	9.00
10.00 01000	DIETARY	5,538	0	98,361	0	348,101	10.00
11.00 01100	CAFETERIA	0	21,002	401,204	0	426,864	11.00
16.00 01600	MEDICAL RECORDS & LIBRARY	494	516	184,579	0	395,113	16.00
17.00 01700	SOCIAL SERVICE	117	1,938	206,413	0	282,237	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	37,648	148,330	2,696,874	0	4,784,330	30.00
31.00 03100	INTENSIVE CARE UNIT	6,287	82,045	2,575,893	0	3,766,746	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	3,410	14,885	702,943	0	1,037,412	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	15,099	361,635	2,140,035	0	4,068,013	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	2,646,665	0	3,499,386	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	369	114,517	498,639	0	902,667	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	165	702	0	0	1,807,512	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	51,127	647,799	0	1,016,153	65.00
66.00 06600	PHYSICAL THERAPY	2,350	1,825	0	0	579,098	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	776	59,681	54,300	0	2,473,252	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	162,901	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	895	81,406	0	0	1,834,295	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	10,479	113,375	1,643,619	0	1,738,137	90.00
90.03 09001	OUTPATIENT LACTATION SERVICES	167	1,347	512,658	0	666,440	90.03
91.00 09100	EMERGENCY	1,671	3,632	870,353	0	931,057	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	118,761	1,569,763	20,259,783	-12,030,777	34,022,451	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	9,850	114,955	0	174,553	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	1,825	0	0	0	51,041	194.00
194.01 07951	WOMEN'S RESOURCES	1,153	21,077	337,596	0	878,282	194.01
194.02 07952	MARKETING	0	0	0	0	460,834	194.02
194.03 07953	REPRODUCTIVE MEDICINE	2,587	15,637	258,423	0	733,583	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,477,140	1,801,557	5,927,143		12,030,777	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.967923	1.114599	0.282638		0.331237	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			61,369		1,267,207	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002926		0.034889	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150149

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

Worksheet B-1
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS REVENUE)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	91,681				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,759,925			8.00
9.00	00900	HOUSEKEEPING	651	0	91,030		9.00
10.00	01000	DIETARY	5,538	0	5,538	28,713	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	0	494	0	16.00
17.00	01700	SOCIAL SERVICE	117	0	117	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,648	7,164,724	37,648	28,713	506
31.00	03100	INTENSIVE CARE UNIT	6,287	10,088,464	6,287	0	427
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,410	3,818,788	3,410	0	155
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,099	20,164,498	15,099	0	391
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,862,835	0	0	480
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	369	0	369	0	85
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	165	0	165	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	112
66.00	06600	PHYSICAL THERAPY	2,350	0	2,350	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	776	0	776	0	18
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	895	0	895	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	10,479	0	10,479	0	127
90.03	09001	OUTPATIENT LACTATION SERVICES	167	0	167	0	82
91.00	09100	EMERGENCY	1,671	2,660,616	1,671	0	95
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,116	51,759,925	85,465	28,713	2,572
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	19
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,825	0	1,825	0	0
194.01	07951	WOMEN'S RESOURCES	1,153	0	1,153	0	83
194.02	07952	MARKETING	0	0	0	0	0
194.03	07953	REPRODUCTIVE MEDICINE	2,587	0	2,587	0	54
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,532,015	688,493	1,194,196	689,003	568,257
203.00		Unit cost multiplier (Wkst. B, Part I)	27.617663	0.013302	13.118708	23.996204	208.305352
204.00		Cost to be allocated (per Wkst. B, Part II)	228,668	18,241	55,865	184,531	39,476
205.00		Unit cost multiplier (Wkst. B, Part II)	2.494170	0.000352	0.613699	6.426741	14.470674

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150149

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

Worksheet B-1

Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (CASE LOAD)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	96,486,228	16.00
17.00	01700	SOCIAL SERVICE	0 22,327	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	8,286,605	30.00
31.00	03100	INTENSIVE CARE UNIT	10,088,464	31.00
32.00	03200	CORONARY CARE UNIT	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	3,818,788 6,267	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	20,164,497	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,862,834	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,874,007	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	10,000,391	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,731,878	65.00
66.00	06600	PHYSICAL THERAPY	1,645,817	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,691,881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	296,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,436,485	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	2,632,936	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	294,071	90.03
91.00	09100	EMERGENCY	2,660,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,486,228 22,327	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	194.01
194.02	07952	MARKETING	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	194.03
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)	557,361 388,822	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005777 17.414879	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,032 16,826	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000322 0.753617	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150149

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

		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	9,006,988		9,006,988	0	9,006,988	7,164,724	30.00
31.00	03100	INTENSIVE CARE UNIT	5,664,970		5,664,970	74,502	5,739,472	10,088,464	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	0	34.00
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	1,734,237		1,734,237	0	1,734,237	3,818,788	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,496,674		6,496,674	0	6,496,674	7,375,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,908,514		4,908,514	0	4,908,514	7,546,623	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,256,782		1,256,782	0	1,256,782	2,003,157	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	2,470,721		2,470,721	0	2,470,721	6,898,877	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,403,406	0	1,403,406	0	1,403,406	4,706,075	65.00
66.00	06600	PHYSICAL THERAPY	876,156	0	876,156	0	876,156	459,131	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,383,835		3,383,835	0	3,383,835	5,187,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,576		218,576	0	218,576	29,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,538,632		2,538,632	0	2,538,632	8,794,353	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	2,782,413		2,782,413	66,304	2,848,717	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	912,773		912,773	0	912,773	290,665	90.03
91.00	09100	EMERGENCY	1,378,079		1,378,079	58,704	1,436,783	540,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	633,552		633,552	0	633,552	16,117	92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	0	111.00
200.00		Subtotal (see instructions)	45,666,308	0	45,666,308	199,510	45,865,818	64,919,880	200.00
201.00		Less Observation Beds	633,552	0	633,552	0	633,552	0	201.00
202.00		Total (see instructions)	45,032,756	0	45,032,756	199,510	45,232,266	64,919,880	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150149

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	PPS	
		Outpatient	Total (col. 6 + col. 7)					
		7.00	8.00					
		9.00	10.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		7,164,724				30.00
31.00	03100	INTENSIVE CARE UNIT		10,088,464				31.00
32.00	03200	CORONARY CARE UNIT		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0				34.00
41.00	04100	SUBPROVIDER - I RF		0				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		3,818,788				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,788,880	20,164,497	0.322184	0.000000	0.322184	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316,211	7,862,834	0.624268	0.000000	0.624268	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,870,850	3,874,007	0.324414	0.000000	0.324414	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000	59.00
60.00	06000	LABORATORY	3,101,514	10,000,391	0.247062	0.000000	0.247062	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	25,803	4,731,878	0.296585	0.000000	0.296585	65.00
66.00	06600	PHYSICAL THERAPY	1,186,686	1,645,817	0.532353	0.000000	0.532353	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,504,623	9,691,881	0.349141	0.000000	0.349141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	267,050	296,958	0.736050	0.000000	0.736050	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,132	10,436,485	0.243246	0.000000	0.243246	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000	CLINIC	2,632,936	2,632,936	1.056772	0.000000	1.081955	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	3,406	294,071	3.103920	0.000000	3.103920	90.03
91.00	09100	EMERGENCY	2,120,493	2,660,616	0.517955	0.000000	0.540019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,105,764	1,121,881	0.564723	0.000000	0.564723	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0				111.00
200.00		Subtotal (see instructions)	31,566,348	96,486,228				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,566,348	96,486,228				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150149

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

			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	9,006,988		9,006,988	0	9,006,988	7,164,724	30.00
31.00	03100	INTENSIVE CARE UNIT	5,664,970		5,664,970	74,502	5,739,472	10,088,464	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	0	34.00
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	1,734,237		1,734,237	0	1,734,237	3,818,788	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,496,674		6,496,674	0	6,496,674	7,375,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,908,514		4,908,514	0	4,908,514	7,546,623	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,256,782		1,256,782	0	1,256,782	2,003,157	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	2,470,721		2,470,721	0	2,470,721	6,898,877	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,403,406	0	1,403,406	0	1,403,406	4,706,075	65.00
66.00	06600	PHYSICAL THERAPY	876,156	0	876,156	0	876,156	459,131	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,383,835		3,383,835	0	3,383,835	5,187,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,576		218,576	0	218,576	29,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,538,632		2,538,632	0	2,538,632	8,794,353	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	2,782,413		2,782,413	66,304	2,848,717	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	912,773		912,773	0	912,773	290,665	90.03
91.00	09100	EMERGENCY	1,378,079		1,378,079	58,704	1,436,783	540,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	633,552		633,552	0	633,552	16,117	92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	0	111.00
200.00		Subtotal (see instructions)	45,666,308	0	45,666,308	199,510	45,865,818	64,919,880	200.00
201.00		Less Observation Beds	633,552	0	633,552	0	633,552	0	201.00
202.00		Total (see instructions)	45,032,756	0	45,032,756	199,510	45,232,266	64,919,880	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150149

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	PPS	
		Outpatient	Total (col. 6 + col. 7)					
		7.00	8.00					
		9.00	10.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		7,164,724				30.00
31.00	03100	INTENSIVE CARE UNIT		10,088,464				31.00
32.00	03200	CORONARY CARE UNIT		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0				34.00
41.00	04100	SUBPROVIDER - I RF		0				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		3,818,788				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,788,880	20,164,497	0.322184	0.000000	0.322184	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316,211	7,862,834	0.624268	0.000000	0.624268	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,870,850	3,874,007	0.324414	0.000000	0.324414	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000	59.00
60.00	06000	LABORATORY	3,101,514	10,000,391	0.247062	0.000000	0.247062	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	25,803	4,731,878	0.296585	0.000000	0.296585	65.00
66.00	06600	PHYSICAL THERAPY	1,186,686	1,645,817	0.532353	0.000000	0.532353	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,504,623	9,691,881	0.349141	0.000000	0.349141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	267,050	296,958	0.736050	0.000000	0.736050	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,132	10,436,485	0.243246	0.000000	0.243246	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0.000000	89.00
90.00	09000	CLINIC	2,632,936	2,632,936	1.056772	0.000000	1.081955	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	3,406	294,071	3.103920	0.000000	3.103920	90.03
91.00	09100	EMERGENCY	2,120,493	2,660,616	0.517955	0.000000	0.540019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,105,764	1,121,881	0.564723	0.000000	0.564723	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0				111.00
200.00		Subtotal (see instructions)	31,566,348	96,486,228				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	31,566,348	96,486,228				202.00

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

Provider CCN: 150149

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

Worksheet C Part II Date/Time Prepared: 5/28/2013 12:44 pm

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	6,496,674	1,039,714	5,456,960	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,908,514	142,080	4,766,434	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,256,782	174,536	1,082,246	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,470,721	72,192	2,398,529	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,403,406	97,479	1,305,927	0	0	65.00
66.00	06600	PHYSICAL THERAPY	876,156	95,796	780,360	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,383,835	180,463	3,203,372	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	218,576	5,779	212,797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,538,632	185,905	2,352,727	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,782,413	520,148	2,262,265	0	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	912,773	32,724	880,049	0	0	90.03
91.00	09100	EMERGENCY	1,378,079	94,175	1,283,904	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	633,552	120,588	512,964	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	29,260,113	2,761,579	26,498,534	0	0	200.00
201.00		Less Observation Beds	633,552	120,588	512,964	0	0	201.00
202.00		Total (Line 200 minus Line 201)	28,626,561	2,640,991	25,985,570	0	0	202.00

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

Provider CCN: 150149

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

Worksheet C Part II Date/Time Prepared: 5/28/2013 12:44 pm

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)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6,496,674	20,164,497	0.322184		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,908,514	7,862,834	0.624268		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,256,782	3,874,007	0.324414		54.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	2,470,721	10,000,391	0.247062		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	1,403,406	4,731,878	0.296585		65.00
66.00	06600 PHYSICAL THERAPY	876,156	1,645,817	0.532353		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,383,835	9,691,881	0.349141		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	218,576	296,958	0.736050		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,538,632	10,436,485	0.243246		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	2,782,413	2,632,936	1.056772		90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	912,773	294,071	3.103920		90.03
91.00	09100 EMERGENCY	1,378,079	2,660,616	0.517955		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	633,552	1,121,881	0.564723		92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0	0	0.000000		99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000		111.00
200.00	Subtotal (sum of lines 50 thru 199)	29,260,113	75,414,252			200.00
201.00	Less Observation Beds	633,552	0			201.00
202.00	Total (Line 200 minus Line 201)	28,626,561	75,414,252			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/28/2013 12:44 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,714,353	0	1,714,353	9,909	173.01	30.00
31.00	INTENSIVE CARE UNIT	443,643		443,643	6,489	68.37	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
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	170,351		170,351	6,267	27.18	43.00
200.00	Total (Lines 30-199)	2,328,347		2,328,347	22,665		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	147	25,432				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
32.00	CORONARY CARE UNIT	0	0				32.00
33.00	BURN INTENSIVE CARE UNIT	0	0				33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (Lines 30-199)	147	25,432				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150149

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

Worksheet D
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

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	1,039,714	20,164,497	0.051562	214,010	11,035	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	142,080	7,862,834	0.018070	22,458	406	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	174,536	3,874,007	0.045053	21,166	954	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	72,192	10,000,391	0.007219	107,550	776	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,479	4,731,878	0.020600	5,391	111	65.00
66.00	06600 PHYSICAL THERAPY	95,796	1,645,817	0.058206	1,374	80	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	180,463	9,691,881	0.018620	117,355	2,185	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,779	296,958	0.019461	16,167	315	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,905	10,436,485	0.017813	90,664	1,615	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	520,148	2,632,936	0.197554	0	0	90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	32,724	294,071	0.111279	1,368	152	90.03
91.00	09100 EMERGENCY	94,175	2,660,616	0.035396	7,944	281	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	120,588	1,121,881	0.107487	0	0	92.00
200.00	Total (lines 50-199)	2,761,579	75,414,252		605,447	17,910	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/28/2013 12:44 pm
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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
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
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
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	9,909	0.00	147	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,489	0.00	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0	34.00
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	6,267	0.00	0	0	43.00
200.00		Total (lines 30-199)	22,665		147	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150149

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

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	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
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	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.03	09001	OUTPATIENT LACTATION SERVICES	0	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
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: 150149

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	20,164,497	0.000000	0.000000	214,010	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,862,834	0.000000	0.000000	22,458	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,874,007	0.000000	0.000000	21,166	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	10,000,391	0.000000	0.000000	107,550	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	4,731,878	0.000000	0.000000	5,391	65.00
66.00	06600	PHYSICAL THERAPY	0	1,645,817	0.000000	0.000000	1,374	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,691,881	0.000000	0.000000	117,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	296,958	0.000000	0.000000	16,167	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,436,485	0.000000	0.000000	90,664	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,632,936	0.000000	0.000000	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	0	294,071	0.000000	0.000000	1,368	90.03
91.00	09100	EMERGENCY	0	2,660,616	0.000000	0.000000	7,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,121,881	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	75,414,252			605,447	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150149

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

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 XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,227,287	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,292	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	91,529	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	275	0	65.00
66.00	06600	PHYSICAL THERAPY	0	130	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	618,712	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	109,082	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	144,540	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	10,670	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	0	0	0	90.03
91.00	09100	EMERGENCY	0	29,676	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	86,080	0	92.00
200.00		Total (lines 50-199)	0	2,413,273	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 12:44 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.322184	1,227,287	0	0	395,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.624268	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324414	95,292	0	0	30,914	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.247062	91,529	0	0	22,613	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.296585	275	0	0	82	65.00
66.00	06600	PHYSICAL THERAPY	0.532353	130	0	0	69	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.349141	618,712	0	0	216,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.736050	109,082	0	0	80,290	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243246	144,540	0	0	35,159	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.056772	10,670	0	0	11,276	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	3.103920	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.517955	29,676	0	0	15,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564723	86,080	0	0	48,611	92.00
200.00		Subtotal (see instructions)		2,413,273	0	0	855,815	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,413,273	0	0	855,815	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 12:44 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
90.03 09001 OUTPATIENT LACTATION SERVICES	0	0		90.03
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			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150149

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

Worksheet D
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Title XIX			Hospital	PPS		
		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	1,714,353	0	1,714,353	9,909	173.01	30.00	
31.00	INTENSIVE CARE UNIT	443,643		443,643	6,489	68.37	31.00	
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00	
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00	
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00	
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	170,351		170,351	6,267	27.18	43.00	
200.00	Total (Lines 30-199)	2,328,347		2,328,347	22,665		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	400	69,204					30.00
31.00	INTENSIVE CARE UNIT	638	43,620					31.00
32.00	CORONARY CARE UNIT	0	0					32.00
33.00	BURN INTENSIVE CARE UNIT	0	0					33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0					34.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	422	11,470					43.00
200.00	Total (Lines 30-199)	1,460	124,294					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150149

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

Worksheet D
Part II
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,039,714	20,164,497	0.051562	2,062,161	106,329	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	142,080	7,862,834	0.018070	2,808,187	50,744	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	174,536	3,874,007	0.045053	741,235	33,395	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	72,192	10,000,391	0.007219	3,686,991	26,616	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,479	4,731,878	0.020600	816,056	16,811	65.00
66.00	06600 PHYSICAL THERAPY	95,796	1,645,817	0.058206	207,867	12,099	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	180,463	9,691,881	0.018620	1,878,024	34,969	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,779	296,958	0.019461	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,905	10,436,485	0.017813	3,499,975	62,345	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	520,148	2,632,936	0.197554	0	0	90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	32,724	294,071	0.111279	78,107	8,692	90.03
91.00	09100 EMERGENCY	94,175	2,660,616	0.035396	224,520	7,947	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	120,588	1,121,881	0.107487	3,729	401	92.00
200.00	Total (lines 50-199)	2,761,579	75,414,252		16,006,852	360,348	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/28/2013 12:44 pm
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Cost Center Description			Title XIX		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
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
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
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	9,909	0.00	400	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,489	0.00	638	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0.00	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0.00	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0	34.00
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	6,267	0.00	422	0	43.00
200.00		Total (lines 30-199)	22,665		1,460	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150149

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	0	0	0	0	90.03
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: 150149

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	20,164,497	0.000000	0.000000	2,062,161	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,862,834	0.000000	0.000000	2,808,187	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,874,007	0.000000	0.000000	741,235	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	10,000,391	0.000000	0.000000	3,686,991	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	4,731,878	0.000000	0.000000	816,056	65.00
66.00	06600	PHYSICAL THERAPY	0	1,645,817	0.000000	0.000000	207,867	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,691,881	0.000000	0.000000	1,878,024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	296,958	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,436,485	0.000000	0.000000	3,499,975	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,632,936	0.000000	0.000000	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	0	294,071	0.000000	0.000000	78,107	90.03
91.00	09100	EMERGENCY	0	2,660,616	0.000000	0.000000	224,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,121,881	0.000000	0.000000	3,729	92.00
200.00		Total (lines 50-199)	0	75,414,252			16,006,852	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150149

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	0	0	0		90.03
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 12:44 pm
	Title XIX	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	0.322184	0	0	1,450,624	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.624268	0	0	55,236	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.324414	0	0	1,327,027	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.247062	0	0	904,337	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.296585	0	0	2,971	0
66.00 06600 PHYSICAL THERAPY	0.532353	0	0	2,294	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.349141	0	0	634,906	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.736050	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.243246	0	0	271,815	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	1.056772	0	0	725,876	0
90.03 09001 OUTPATIENT LACTATION SERVICES	3.103920	0	0	1,621	0
91.00 09100 EMERGENCY	0.517955	0	0	898,482	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.564723	0	0	101,148	0
200.00 Subtotal (see instructions)		0	0	6,376,337	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	6,376,337	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/28/2013 12:44 pm
		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	0	467,368	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	34,482	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	430,506	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	223,427	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	881	65.00
66.00	06600 PHYSICAL THERAPY	0	1,221	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221,672	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	66,118	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	767,085	90.00
90.03	09001 OUTPATIENT LACTATION SERVICES	0	5,031	90.03
91.00	09100 EMERGENCY	0	465,373	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	57,121	92.00
200.00	Subtotal (see instructions)	0	2,740,285	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,740,285	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2013 12:44 pm
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)		9,909	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,909	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.		9,212	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	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)		147	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)		147	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)		9,006,988	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)		9,006,988	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,164,724	28.00
29.00	Private room charges (excluding swing-bed charges)		7,164,724	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.257130	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		777.76	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		777.76	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		977.75	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		9,007,033	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		-45	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)		908.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		133,619	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)		133,619	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/28/2013 12:44 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,739,472	6,489	884.49	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					202,203	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					335,822	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)					25,432	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					17,910	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					43,342	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					292,480	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)					697	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					908.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					633,552	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150149		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/28/2013 12:44 pm	
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	1,714,353	9,006,988	0.190336	633,552	120,588	90.00
91.00	Nursing School cost	0	9,006,988	0.000000	633,552	0	91.00
92.00	Allied health cost	0	9,006,988	0.000000	633,552	0	92.00
93.00	All other Medical Education	0	9,006,988	0.000000	633,552	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/28/2013 12:44 pm
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)		9,909	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,909	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.		9,212	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	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)		400	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)		400	14.00
15.00	Total nursery days (title V or XIX only)		6,267	15.00
16.00	Nursery days (title V or XIX only)		422	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)		9,006,988	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)		9,006,988	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,164,724	28.00
29.00	Private room charges (excluding swing-bed charges)		7,164,724	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.257130	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		777.76	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		777.76	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		977.75	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		9,007,033	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		-45	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)		908.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		363,588	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)		363,588	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/28/2013 12:44 pm	
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	1,734,237	6,267	276.73	422	116,780	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	5,739,472	6,489	884.49	638	564,305	43.00
44.00	0	0	0.00	0	0	44.00
45.00	0	0	0.00	0	0	45.00
46.00	0	0	0.00	0	0	46.00
47.00						47.00
Cost Center Description						
48.00					5,794,366	48.00
49.00					6,839,039	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00					124,294	50.00
51.00					360,348	51.00
52.00					484,642	52.00
53.00					6,354,397	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00					0	54.00
55.00					0.00	55.00
56.00					0	56.00
57.00					0	57.00
58.00					0	58.00
59.00					0.00	59.00
60.00					0.00	60.00
61.00					0	61.00
62.00					0	62.00
63.00					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00					0	64.00
65.00					0	65.00
66.00					0	66.00
67.00					0	67.00
68.00					0	68.00
69.00					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00						70.00
71.00						71.00
72.00						72.00
73.00						73.00
74.00						74.00
75.00						75.00
76.00						76.00
77.00						77.00
78.00						78.00
79.00						79.00
80.00						80.00
81.00						81.00
82.00						82.00
83.00						83.00
84.00						84.00
85.00						85.00
86.00						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00					697	87.00
88.00					908.97	88.00
89.00					633,552	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150149		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/28/2013 12:44 pm	
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	1,714,353	9,006,988	0.190336	633,552	120,588	90.00
91.00	Nursing School cost	0	9,006,988	0.000000	633,552	0	91.00
92.00	Allied health cost	0	9,006,988	0.000000	633,552	0	92.00
93.00	All other Medical Education	0	9,006,988	0.000000	633,552	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/28/2013 12:44 pm	
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		118,247	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		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	0.322184	214,010	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.624268	22,458	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324414	21,166	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.247062	107,550	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.296585	5,391	65.00
66.00	06600	PHYSICAL THERAPY	0.532353	1,374	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.349141	117,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.736050	16,167	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243246	90,664	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.081955	0	90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	3.103920	1,368	90.03
91.00	09100	EMERGENCY	0.540019	7,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564723	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		605,447	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)		605,447	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/28/2013 12:44 pm
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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		2,242,077	30.00
31.00	03100	INTENSIVE CARE UNIT		4,471,970	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		1,372,574	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.322184	2,062,161	664,395 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.624268	2,808,187	1,753,061 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.324414	741,235	240,467 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.247062	3,686,991	910,915 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.296585	816,056	242,030 65.00
66.00	06600	PHYSICAL THERAPY	0.532353	207,867	110,659 66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.349141	1,878,024	655,695 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.736050	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243246	3,499,975	851,355 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000	CLINIC	1.081955	0	0 90.00
90.03	09001	OUTPATIENT LACTATION SERVICES	3.103920	78,107	242,438 90.03
91.00	09100	EMERGENCY	0.540019	224,520	121,245 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.564723	3,729	2,106 92.00
200.00		Total (sum of lines 50-94 and 96-98)		16,006,852	5,794,366 200.00
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)		16,006,852	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/28/2013 12:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		233,349	1.00
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		72.10	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		27.85	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		39.40	31.00
32.00	Sum of lines 30 and 31		67.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		28,002	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)		261,351	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)		261,351	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		18,528	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		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: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/28/2013 12:44 pm
		Title XVIII	Hospital	PPS
				1.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			279,879 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			279,879 61.00
62.00	Deductibles billed to program beneficiaries			39,280 62.00
63.00	Coinurance billed to program beneficiaries			0 63.00
64.00	Allowable bad debts (see instructions)			-1,132 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			-792 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-1,132 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			239,807 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			206 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 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)			240,013 71.00
72.00	Interim payments			240,805 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)			-792 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/28/2013 12:44 pm
		Title XVII	Hospital	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)		855,815	2.00
3.00	PPS payments		490,005	3.00
4.00	Outlier payment (see instructions)		27,749	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)		517,754	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)		129,461	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)		388,293	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)		388,293	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		388,293	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)		16,236	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		11,365	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,236	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		399,658	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)		399,658	40.00
41.00	Interim payments		388,292	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		11,366	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: 150149

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2013 12:44 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		240,805		388,292	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)		240,805		388,292	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		11,366	6.01
6.02	SETTLEMENT TO PROGRAM		792		0	6.02
7.00	Total Medicare program liability (see instructions)		240,013		399,658	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 150149

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

Worksheet G

Date/Time Prepared:
5/28/2013 12:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	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	19,310,461	0	0	0	4.00
5.00	Other receivable	1,584,340	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,091,660	0	0	0	6.00
7.00	Inventory	447,038	0	0	0	7.00
8.00	Prepaid expenses	816,586	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,066,765	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,349,089	0	0	0	15.00
16.00	Accumulated depreciation	-399,049	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	12,760,994	0	0	0	19.00
20.00	Accumulated depreciation	-9,206,554	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,504,480	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	527,255	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	527,255	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,098,500	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,959,797	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,306,755	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	849,706	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	41,035	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,157,293	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	850,790	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	850,790	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,008,083	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,090,417				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)	10,090,417	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,098,500	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150149

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

Worksheet G-1

Date/Time Prepared:
5/28/2013 12:44 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		6,131,519		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,737,825			2.00
3.00	Total (sum of line 1 and line 2)		17,869,344		0	3.00
4.00	ROUNDING	-5		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)		-5		0	10.00
11.00	Subtotal (line 3 plus line 10)		17,869,339		0	11.00
12.00	DISTRIBUTION TO MEMBERS	7,778,922		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)		7,778,922		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,090,417		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	DISTRIBUTION TO MEMBERS		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: 150149

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2013 12:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,983,512		10,983,512	1.00
2.00	SUBPROVIDER - IPF				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				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)	10,983,512		10,983,512	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,782,799		14,782,799	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,782,799		14,782,799	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,766,311		25,766,311	17.00
18.00	Ancillary services	43,000,997	32,046,536	75,047,533	18.00
19.00	Outpatient services	846,904	10,407,064	11,253,968	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE COST CENTERS	0	368,769	368,769	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	69,614,212	42,822,369	112,436,581	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		54,904,640		29.00
30.00	BAD DEBTS	1,907,685			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)		1,907,685		36.00
37.00	LOSS ON DISPOSAL OF ASSETS	-92,321			37.00
38.00	SALE OF SCRAP	15			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)		-92,306		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		56,904,631		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150149

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

Worksheet G-3

Date/Time Prepared:
5/28/2013 12:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	112,436,581	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,203,139	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,233,442	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,904,631	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,328,811	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	23,252	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	384,583	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	498,204	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	502,975	24.00
25.00	Total other income (sum of lines 6-24)	1,409,014	25.00
26.00	Total (line 5 plus line 25)	11,737,825	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)	11,737,825	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/28/2013 12:44 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		18,528	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		42.90	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		18,528	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

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150149	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/28/2013 12:44 pm
		Title XIX	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		0	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		0.00	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		0	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