

**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report Date: 2/27/2013 Time: 7:57 pm  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only  
 5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended  
 6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN  
 10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEART HOSPITAL AT DEACONESS GATEWAY ( 150175 ) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information  
 ECR: Date: 2/27/2013 Time: 7:57 pm  
 aehqzjnt1qomHu:0EEqKFTWIXs4ZCO  
 ZOEOR0zza8YrFOGjHEcn2dvuj65GTS  
 g:LQ0GIVAn0XDpvm  
 PI: Date: 2/27/2013 Time: 7:57 pm  
 u0JujfrZVKmjfdw2gi0I55TLFNwh00  
 ribk30dxXgv0daoL30FhfJk2NujDfx  
 ZW7BftBUKW023Z:4

(signed) *Rebecca L. Malotte*  
 Officer or Administrator of Provider(s)  
*Executive Director + CNO*  
 Title  
*February 28, 2013*  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	Hospital	0	14,382	52,707	32,300	0 1.00
2.00	Subprovider - IPF	0	0	0		0 2.00
3.00	Subprovider - IRF	0	0	0		0 3.00
4.00	SUBPROVIDER I	0	0	0		0 4.00
5.00	Swing bed - SNF	0	0	0		0 5.00
6.00	Swing bed - NF	0	0	0		0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0 7.00
8.00	NURSING FACILITY	0	0	0		0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0		0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0 11.00
12.00	CMHC I	0	0	0		0 12.00
200.00	Total	0	14,382	52,707	32,300	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: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 7:56 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 4007 GATEWAY BOULEVARD		PO Box:						1.00		
2.00	City: NEWBURGH		State: IN		Zip Code: 47630-		County: WARRICK		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		HEART HOSPITAL AT DEACONESS GATEWAY	150175	21780	1	02/23/2009	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
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)					10/01/2011	09/30/2012		20.00		
21.00	Type of Control (see instructions)					4			21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0	0	25.00	
						Urban/Rural S	Date of Geogr				
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0				35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/27/2013 7:56 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.	N				39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 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)		0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
<b>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	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	0	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	0	0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00			
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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	
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00	
		1.00					
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N					
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N					
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.						
		V		XIX			
		1.00		2.00			
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y			
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			
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			
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			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N			
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			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	
		1.00		2.00		3.00	
						Respiratory	
						4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
		1.00		2.00		3.00	
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	37,057	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		
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
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.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		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.			Y	
			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

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							1.00	
<b>Multi campus</b>								
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	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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)						0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 7:56 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.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	02/12/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		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		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		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/27/2013 7:56 pm
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		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been 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
<b>Interest Expense</b>				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
<b>Home Office Costs</b>				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
				1.00
				2.00
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	WENDY	FRUMKIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-450-7423	WENDY.FRUMKIN@DEACONESS.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/12/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	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		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		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT COORDINATOR		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: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	24	8,784	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		24	8,784	0.00		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)		24	8,784	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		24				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 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	3,508	232	6,152		1.00
2.00 HMO		652	60			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	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,508	232	6,152		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	3,508	232	6,152		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	729		28.00
29.00 Ambulance Trips			0			29.00
30.00 Employee discount days (see instruction)				64		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	897	1.00
2.00 HMO					161	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	134.00	0.00	0	897	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	134.00	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 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	42	1,697		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	42	1,697		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				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: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet S-3 Part II Date/Time Prepared: 2/27/2013 7:56 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		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	6,530,174	659,679	7,189,853	262,947.22	27.34	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		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	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)		0	0	0	0.00	0.00	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
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		895	0	895	5.25	170.48	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	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
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		2,305,336	0	2,305,336			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		0	0	0			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	468,336	5,994	474,330	12,034.31	39.41	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	41.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150175			Period: From 10/01/2011 To 09/30/2012		Worksheet S-3 Part II Date/Time Prepared: 2/27/2013 7:56 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
42.00	Soci al Servi ce	17.00	0	0	0.00	0.00	42.00	
43.00	Other General Servi ce	18.00	0	0	0.00	0.00	43.00	

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2013 7:56 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	6,530,174	659,679	7,189,853	262,947.22	27.34	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	6,530,174	659,679	7,189,853	262,947.22	27.34	3.00
4.00	Subtotal other wages & related costs (see inst.)	895	0	895	5.25	170.48	4.00
5.00	Subtotal wage-related costs (see inst.)	2,305,336	0	2,305,336	0.00	32.06	5.00
6.00	Total (sum of lines 3 thru 5)	8,836,405	659,679	9,496,084	262,952.47	36.11	6.00
7.00	Total overhead cost (see instructions)	468,336	5,994	474,330	12,034.31	39.41	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2013 7:56 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			225,897 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)			287,253 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			961,373 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			34,248 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			3,155 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			70 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			126,937 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			48,427 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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			543,103 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			7,547 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			11,656 21.00
22.00	Day Care Cost and Allowances			4,032 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			2,253,698 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
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			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			14.00
15.00	Hospital -Based Health Clinic FQHC			15.00
16.00	Hospital -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/27/2013 7:56 pm
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.259029		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		1,142,980		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		4,159,344		6.00
7.00	Medicaid cost (line 1 times line 6)		1,077,391		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
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
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,215,367	239,933	2,455,300	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	573,844	62,150	635,994	21.00
22.00	Partial payment by patients approved for charity care	2,399	0	2,399	22.00
23.00	Cost of charity care (line 21 minus line 22)	571,445	62,150	633,595	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)		1,529,648		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		57,696		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,471,952		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		381,278		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,014,873		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,014,873		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/27/2013 7:56 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	1,652,815	1,652,815	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1,613,647	1,613,647	2.00
4.00	00400	EMPLOYEE BENEFITS	0	2,561,504	53,412	2,614,916	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	468,336	8,026,091	-3,051,708	5,442,719	5.00
7.00	00700	OPERATION OF PLANT	0	442,490	0	442,490	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,446	0	71,446	8.00
9.00	00900	HOUSEKEEPING	0	168,684	0	168,684	9.00
10.00	01000	DIETARY	0	237,384	0	237,384	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	59,845	-285	59,560	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	202,355	-78,137	124,218	14.00
15.00	01500	PHARMACY	0	2,289,603	-1,622,790	666,813	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	529,554	0	529,554	16.00
17.00	01700	SOCIAL SERVICE	0	172,427	0	172,427	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,855,099	338,021	-148,212	3,044,908	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	527,376	4,898,142	-2,942,617	2,482,901	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,511	71,426	149,937	151,431	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,147,550	9,842,818	-9,188,188	2,802,180	59.00
60.00	06000	LABORATORY	0	1,354,727	0	1,354,727	60.00
64.00	06400	INTRAVENOUS THERAPY	129,624	33,033	-55,744	106,913	64.00
65.00	06500	RESPIRATORY THERAPY	0	163,732	0	163,732	65.00
66.00	06600	PHYSICAL THERAPY	0	109,341	0	109,341	66.00
69.00	06900	ELECTROCARDIOLOGY	49,485	21,720	-114,086	-42,881	69.00
69.01	06902	CARDIAC REHAB	218,363	55,889	-24,768	249,484	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,797,808	3,797,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	8,498,432	8,498,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,617,514	1,617,514	73.00
74.00	07400	RENAL DIALYSIS	55,830	45,315	-8,587	92,558	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,530,174	31,695,547	0	38,225,721	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	23,316	0	23,316	194.01
194.02	07952	PUBLIC RELATIONS	0	15,998	0	15,998	194.02
200.00		TOTAL (SUM OF LINES 118-199)	6,530,174	31,734,861	0	38,265,035	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100			1.00
	NEW CAP REL COSTS-BLDG & FIXT	0	1,652,815	
2.00	00200			2.00
	NEW CAP REL COSTS-MVBLE EQUIP	0	1,613,647	
4.00	00400	-1,025,934	1,588,982	4.00
	EMPLOYEE BENEFITS			
5.00	00500	-1,130,603	4,312,116	5.00
	ADMINISTRATIVE & GENERAL			
7.00	00700	0	442,490	7.00
	OPERATION OF PLANT			
8.00	00800	2,304	73,750	8.00
	LAUNDRY & LINEN SERVICE			
9.00	00900	0	168,684	9.00
	HOUSEKEEPING			
10.00	01000	-53,867	183,517	10.00
	DIETARY			
11.00	01100	68,789	68,789	11.00
	CAFETERIA			
13.00	01300	0	59,560	13.00
	NURSING ADMINISTRATION			
14.00	01400	0	124,218	14.00
	CENTRAL SERVICES & SUPPLY			
15.00	01500	0	666,813	15.00
	PHARMACY			
16.00	01600	-82,885	446,669	16.00
	MEDICAL RECORDS & LIBRARY			
17.00	01700	0	172,427	17.00
	SOCIAL SERVICE			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	0	3,044,908	30.00
	ADULTS & PEDIATRICS			
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	-1,528,795	954,106	50.00
	OPERATING ROOM			
54.00	05400	-60,648	90,783	54.00
	RADIOLOGY-DIAGNOSTIC			
59.00	05900	-61,110	2,741,070	59.00
	CARDIAC CATHETERIZATION			
60.00	06000	395,736	1,750,463	60.00
	LABORATORY			
64.00	06400	0	106,913	64.00
	INTRAVENOUS THERAPY			
65.00	06500	281,549	445,281	65.00
	RESPIRATORY THERAPY			
66.00	06600	-63,748	45,593	66.00
	PHYSICAL THERAPY			
69.00	06900	-80,000	-122,881	69.00
	ELECTROCARDIOLOGY			
69.01	06902	-8,132	241,352	69.01
	CARDIAC REHAB			
71.00	07100	155,712	3,953,520	71.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS			
72.00	07200	0	8,498,432	72.00
	IMPL. DEV. CHARGED TO PATIENT			
73.00	07300	0	1,617,514	73.00
	DRUGS CHARGED TO PATIENTS			
74.00	07400	-483	92,075	74.00
	RENAL DIALYSIS			
76.00	03020	1,025	1,025	76.00
	OTHER ANCILLARY SERVICE COST CENTERS			
<b>OUTPATIENT SERVICE COST CENTERS</b>				
92.00	09200			92.00
	OBSERVATION BEDS (NON-DISTINCT PART)			
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		-3,191,090	35,034,631	118.00
	SUBTOTALS (SUM OF LINES 1-117)			
<b>NONREIMBURSABLE COST CENTERS</b>				
194.00	07950	0	0	194.00
	OTHER NONREIMBURSABLE COST CENTERS			
194.01	07951	0	23,316	194.01
	VISITOR ASSISTANTS			
194.02	07952	0	15,998	194.02
	PUBLIC RELATIONS			
200.00		-3,191,090	35,073,945	200.00
	TOTAL (SUM OF LINES 118-199)			

RECLASSIFICATIONS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6  
Date/Time Prepared:  
2/27/2013 7:56 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EQUIPMENT DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	463,740	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	463,740	
<b>B - LEASES</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,633,159	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,113,907	2.00
	TOTALS		0	2,747,066	
<b>C - INSURANCE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	19,656	1.00
	TOTALS		0	19,656	
<b>D - PROPERTY TAXES</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	36,000	1.00
	TOTALS		0	36,000	
<b>E - MEDICAL SUPPLIES AND DRUGS CHARGED</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,797,808	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,498,432	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,617,514	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	13,913,754	
<b>F - PROEFSSIONAL FEES</b>					
1.00	CARDIAC CATHETERIZATION	59.00	0	80,000	1.00
2.00	RENAL DIALYSIS	74.00	0	895	2.00
	TOTALS		0	80,895	
<b>G - INCENTIVE COMPENSATION</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	6,980	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	67,283	0	2.00
3.00	OPERATING ROOM	50.00	11,100	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	1,494	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	42,323	0	5.00
6.00	INTRAVENOUS THERAPY	64.00	7,027	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	9,366	0	7.00
8.00	CARDIAC REHAB	69.01	6,548	0	8.00
9.00	RENAL DIALYSIS	74.00	970	0	9.00
	TOTALS		153,091	0	
<b>H - SALARIES</b>					
1.00	ELECTROCARDIOLOGY	69.00	320,000	0	1.00
2.00	INTRAVENOUS THERAPY	64.00	240,000	0	2.00
	TOTALS		560,000	0	
<b>I - SHORT TERM DISABILITY</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	53,412	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	53,412	
500.00	Grand Total : Increases		713,091	17,314,523	500.00

RECLASSIFICATIONS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6  
Date/Time Prepared:  
2/27/2013 7:56 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - EQUIPMENT DEPRECIATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,994	9		1.00
2.00	NURSING ADMINISTRATION	13.00	0	285	9		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	43,465	9		3.00
4.00	OPERATING ROOM	50.00	0	107,058	9		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	167,100	9		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	90,386	9		6.00
7.00	CARDIAC REHAB	69.01	0	24,000	9		7.00
8.00	RENAL DIALYSIS	74.00	0	10,452	9		8.00
	<b>TOTALS</b>		0	463,740			
<b>B - LEASES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,747,066	10		1.00
2.00		0.00	0	0	10		2.00
	<b>TOTALS</b>		0	2,747,066			
<b>C - INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,656	12		1.00
	<b>TOTALS</b>		0	19,656			
<b>D - PROPERTY TAXES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,000	13		1.00
	<b>TOTALS</b>		0	36,000			
<b>E - MEDICAL SUPPLIES AND DRUGS CHARGED</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	78,137	0		1.00
2.00	PHARMACY	15.00	0	1,622,790	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	137,222	0		3.00
4.00	OPERATING ROOM	50.00	0	2,846,659	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	9,129,656	0		5.00
6.00	INTRAVENOUS THERAPY	64.00	0	62,771	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	32,852	0		7.00
8.00	CARDIAC REHAB	69.01	0	3,667	0		8.00
	<b>TOTALS</b>		0	13,913,754			
<b>F - PROFESSIONAL FEES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,895	0		1.00
2.00		0.00	0	0	0		2.00
	<b>TOTALS</b>		0	80,895			
<b>G - INCENTIVE COMPENSATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	153,091	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	<b>TOTALS</b>		0	153,091			
<b>H - SALARIES</b>							
1.00	ELECTROCARDIOLOGY	69.00	0	320,000	0		1.00
2.00	INTRAVENOUS THERAPY	64.00	0	240,000	0		2.00
	<b>TOTALS</b>		0	560,000			
<b>I - SHORT TERM DISABILITY</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	986	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	34,808	0	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	13,755	0	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	214	0	0		4.00
5.00	CARDIAC REHAB	69.01	3,649	0	0		5.00
	<b>TOTALS</b>		53,412	0	0		
500.00	<b>Grand Total: Decreases</b>		53,412	17,974,202			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2013 7:56 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	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	0	0	0	0	4.00
5.00	Fixed Equipment	5,274,221	694,857	0	694,857	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,274,221	694,857	0	694,857	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,274,221	694,857	0	694,857	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/27/2013 7:56 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	5,969,078	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	5,969,078	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	5,969,078	0			10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	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
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,633,159
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	463,740	1,113,907
3.00	Total (sum of lines 1-2)	0	0	0	463,740	2,747,066

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	19,656	0	0	1,652,815	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	36,000	0	1,613,647	2.00
3.00	Total (sum of lines 1-2)	0	19,656	36,000	0	3,266,462	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
2/27/2013 7:56 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 #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 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)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-141,593		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,504,936		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests		0		0.00 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		0		0.00 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		RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** 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			*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant				0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 NON-PATIENT REVENUE	B	-1,733	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00 SELF INSURANCE	A	-1,025,934	EMPLOYEE BENEFITS	4.00 34.00
35.00 RESEARCH	A	-516,894	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 36.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 37.00
38.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 38.00
39.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,191,090		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	NON-PATIENT REVENUE	0	33.00
34.00	SELF INSURANCE	0	34.00
35.00	RESEARCH	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:  
2/27/2013 7:56 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	BUILDING LEASE	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	LEASES	2.00
3.00	4.00	EMPLOYEE BENEFITS	BENEFITS	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACT SERVICES	4.00
4.01	7.00	OPERATION OF PLANT	CONTRACT SERVICES	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	CONTRACT SERVICES	4.02
4.03	9.00	HOUSEKEEPING	CONTRACT SERVICES	4.03
4.04	10.00	DIETARY	CONTRACT SERVICES	4.04
4.05	11.00	CAFETERIA	CONTRACT SERVICES	4.05
4.06	13.00	NURSING ADMINISTRATION	CONTRACT SERVICES	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY	CONTRACT SERVICES	4.07
4.08	15.00	PHARMACY	CONTRACT SERVICES	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	CONTRACT SERVICES	4.09
4.10	17.00	SOCIAL SERVICE	CONTRACT SERVICES	4.10
4.11	30.00	ADULTS & PEDIATRICS	CONTRACT SERVICES	4.11
4.12	50.00	OPERATING ROOM	CONTRACT SERVICES	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	CONTRACT SERVICES	4.13
4.14	59.00	CARDIAC CATHETERIZATION	CONTRACT SERVICES	4.14
4.15	60.00	LABORATORY	CONTRACT SERVICES	4.15
4.16	64.00	INTRAVENOUS THERAPY	CONTRACT SERVICES	4.16
4.17	65.00	RESPIRATORY THERAPY	CONTRACT SERVICES	4.17
4.18	69.00	ELECTROCARDIOLOGY	CONTRACT SERVICES	4.18
4.19	69.01	CARDIAC REHAB	CONTRACT SERVICES	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	CONTRACT SERVICES	4.20
4.21	74.00	RENAL DIALYSIS	CONTRACT SERVICES	4.21
4.22	76.00	OTHER ANCILLARY SERVICE COST CENTERS	CONTRACT SERVICES	4.22
4.23	69.01	CARDIAC REHAB	FACILITY RENT	4.23
4.24	66.00	PHYSICAL THERAPY	THERAPY SERVICES	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			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	
	1.00	2.00	3.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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		51.00	6.00
7.00	B		51.00	7.00
8.00	B		51.00	8.00
9.00	B		51.00	9.00
10.00	B		51.00	10.00
10.01	B		51.00	10.01
10.02	B		51.00	10.02
10.03	B		51.00	10.03
10.04	B		51.00	10.04
10.05	B		51.00	10.05
10.06	B		51.00	10.06
10.07	B		51.00	10.07
10.08	B		51.00	10.08
10.09	B		51.00	10.09
10.10	B		51.00	10.10
10.11	B		51.00	10.11
10.12	B		51.00	10.12
10.13	B		51.00	10.13
10.14	B		51.00	10.14
10.15	B		51.00	10.15
10.16	B		51.00	10.16
10.17	B		51.00	10.17
10.18	B		51.00	10.18

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

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:  
2/27/2013 7:56 pm

		Symbol (1)	Name	Percentage of Ownership	
		1.00	2.00	3.00	
10.19		B		51.00	10.19
10.20		B		51.00	10.20
10.21		B		51.00	10.21
10.22		B		0.00	10.22
10.23		A		0.00	10.23
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: 150175

Period: From 10/01/2011 To 09/30/2012

Worksheet A-8-1

Date/Time Prepared: 2/27/2013 7:56 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	2,363,387	2,363,387	0	10	1.00
2.00	300,058	300,058	0	10	2.00
3.00	2,542,113	2,542,113	0	0	3.00
4.00	2,705,533	3,317,509	-611,976	0	4.00
4.01	169,790	169,790	0	0	4.01
4.02	73,750	71,446	2,304	0	4.02
4.03	168,684	168,684	0	0	4.03
4.04	183,517	237,384	-53,867	0	4.04
4.05	68,789	0	68,789	0	4.05
4.06	59,560	59,560	0	0	4.06
4.07	79,574	79,574	0	0	4.07
4.08	666,813	666,813	0	0	4.08
4.09	446,669	529,554	-82,885	0	4.09
4.10	107,622	107,622	0	0	4.10
4.11	2,875,543	2,875,543	0	0	4.11
4.12	586,683	2,115,478	-1,528,795	0	4.12
4.13	389,544	450,192	-60,648	0	4.13
4.14	2,174,821	2,174,821	0	0	4.14
4.15	1,750,463	1,354,727	395,736	0	4.15
4.16	79,659	79,659	0	0	4.16
4.17	445,281	163,732	281,549	0	4.17
4.18	454,986	454,986	0	0	4.18
4.19	218,954	218,954	0	0	4.19
4.20	155,712	0	155,712	0	4.20
4.21	58,166	58,166	0	0	4.21
4.22	1,025	0	1,025	0	4.22
4.23	46,031	54,163	-8,132	0	4.23
4.24	45,593	109,341	-63,748	0	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	19,218,320	20,723,256	-1,504,936	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			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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	DEACONESS HOSPITAL	0.00	HOSPITAL	6.00
7.00	DEACONESS HOSPITAL	0.00	HOSPITAL	7.00
8.00	DEACONESS HOSPITAL	0.00	HOSPITAL	8.00
9.00	DEACONESS HOSPITAL	0.00	HOSPITAL	9.00
10.00	DEACONESS HOSPITAL	0.00	HOSPITAL	10.00
10.01	DEACONESS HOSPITAL	0.00	HOSPITAL	10.01
10.02	DEACONESS HOSPITAL	0.00	HOSPITAL	10.02
10.03	DEACONESS HOSPITAL	0.00	HOSPITAL	10.03
10.04	DEACONESS HOSPITAL	0.00	HOSPITAL	10.04
10.05	DEACONESS HOSPITAL	0.00	HOSPITAL	10.05
10.06	DEACONESS HOSPITAL	0.00	HOSPITAL	10.06
10.07	DEACONESS HOSPITAL	0.00	HOSPITAL	10.07
10.08	DEACONESS HOSPITAL	0.00	HOSPITAL	10.08
10.09	DEACONESS HOSPITAL	0.00	HOSPITAL	10.09
10.10	DEACONESS HOSPITAL	0.00	HOSPITAL	10.10
10.11	DEACONESS HOSPITAL	0.00	HOSPITAL	10.11
10.12	DEACONESS HOSPITAL	0.00	HOSPITAL	10.12
10.13	DEACONESS HOSPITAL	0.00	HOSPITAL	10.13
10.14	DEACONESS HOSPITAL	0.00	HOSPITAL	10.14
10.15	DEACONESS HOSPITAL	0.00	HOSPITAL	10.15

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

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-1

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		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
10.16		DEACONESS HOSPITAL	0.00	HOSPITAL	10.16
10.17		DEACONESS HOSPITAL	0.00	HOSPITAL	10.17
10.18		DEACONESS HOSPITAL	0.00	HOSPITAL	10.18
10.19		DEACONESS HOSPITAL	0.00	HOSPITAL	10.19
10.20		DEACONESS HOSPI	0.00	HOSPITAL	10.20
10.21		DEACONESS HOSPI	0.00	HOSPITAL	10.21
10.22		DEAC HEALTH SYS	0.00	HEALTH SYSTEM	10.22
10.23		PROGRESSIVE HEA	51.00	THERAPY PROVIDE	10.23
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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 7:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	59.00	CARDIAC CATHETERIZATION	61,110	61,110	1.00
2.00	69.00	ELECTROCARDIOLOGY	80,000	80,000	2.00
3.00	74.00	RENAL DIALYSIS	895	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
200.00			142,005	141,110	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 7:56 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	895	171,400	5	412	21	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	895		5	412	21	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/27/2013 7:56 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	412	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	412	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	61,110	1.00
2.00	0	80,000	2.00
3.00	483	483	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	483	141,593	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
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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	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,652,815	1,652,815			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,613,647		1,613,647		2.00
4.00 00400	EMPLOYEE BENEFITS	1,588,982	0	0	1,588,982	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,312,116	57,089	73,048	104,828	4,547,081
7.00 00700	OPERATION OF PLANT	442,490	5,597	0	0	448,087
8.00 00800	LAUNDRY & LINEN SERVICE	73,750	0	0	0	73,750
9.00 00900	HOUSEKEEPING	168,684	8,450	0	0	177,134
10.00 01000	DIETARY	183,517	0	0	0	183,517
11.00 01100	CAFETERIA	68,789	0	0	0	68,789
13.00 01300	NURSING ADMINISTRATION	59,560	0	992	0	60,552
14.00 01400	CENTRAL SERVICES & SUPPLY	124,218	0	0	0	124,218
15.00 01500	PHARMACY	666,813	0	0	0	666,813
16.00 01600	MEDICAL RECORDS & LIBRARY	446,669	0	0	0	446,669
17.00 01700	SOCIAL SERVICE	172,427	0	0	0	172,427
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,044,908	786,470	151,243	638,165	4,620,786
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	954,106	255,982	372,524	119,005	1,701,617
54.00 05400	RADIOLOGY-DIAGNOSTIC	90,783	0	0	17,681	108,464
59.00 05900	CARDIAC CATHETERIZATION	2,741,070	539,227	581,449	480,929	4,342,675
60.00 06000	LABORATORY	1,750,463	0	0	0	1,750,463
64.00 06400	INTRAVENOUS THERAPY	106,913	0	0	83,241	190,154
65.00 06500	RESPIRATORY THERAPY	445,281	0	0	0	445,281
66.00 06600	PHYSICAL THERAPY	45,593	0	0	0	45,593
69.00 06900	ELECTROCARDIOLOGY	-122,881	0	314,511	83,680	275,310
69.01 06902	CARDIAC REHAB	241,352	0	83,511	48,900	373,763
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,953,520	0	0	0	3,953,520
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	8,498,432	0	0	0	8,498,432
73.00 07300	DRUGS CHARGED TO PATIENTS	1,617,514	0	0	0	1,617,514
74.00 07400	RENAL DIALYSIS	92,075	0	36,369	12,553	140,997
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	1,025	0	0	0	1,025
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,034,631	1,652,815	1,613,647	1,588,982	35,034,631
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07951	VISITOR ASSISTANTS	23,316	0	0	0	23,316
194.02 07952	PUBLIC RELATIONS	15,998	0	0	0	15,998
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	35,073,945	1,652,815	1,613,647	1,588,982	35,073,945

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	4,547,081				5.00	
7.00	00700	OPERATION OF PLANT	66,744	514,831			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	10,985		84,735		8.00	
9.00	00900	HOUSEKEEPING	26,385	2,736	0	206,255	9.00	
10.00	01000	DIETARY	27,335	0	0	0	10.00	
11.00	01100	CAFETERIA	10,246	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	9,019	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	18,503	0	0	0	14.00	
15.00	01500	PHARMACY	99,324	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	66,533	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	25,684	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	688,280	254,633	51,714	102,557	204,836	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	253,461	82,878	10,385	33,381	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,156	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	646,854	174,584	17,690	70,317	6,016	59.00
60.00	06000	LABORATORY	260,737	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	28,324	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	66,326	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,791	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	41,008	0	4,946	0	0	69.00
69.01	06902	CARDIAC REHAB	55,673	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	588,889	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,265,879	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	240,934	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,002	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	153	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,541,225	514,831	84,735	206,255	210,852	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	3,473	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	2,383	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,547,081	514,831	84,735	206,255	210,852	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	79,035					11.00
13.00	01300	0	69,571				13.00
14.00	01400	0	0	142,721			14.00
15.00	01500	0	0	0	766,137		15.00
16.00	01600	0	0	0	0	513,202	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	36,401	34,607	0	0	43,668	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	5,985	5,710	0	0	44,596	50.00
54.00	05400	802	0	0	0	15,448	54.00
59.00	05900	22,952	21,772	0	0	181,836	59.00
60.00	06000	0	0	0	0	31,890	60.00
64.00	06400	3,825	3,616	0	0	1,022	64.00
65.00	06500	0	0	0	0	5,418	65.00
66.00	06600	0	0	0	0	2,581	66.00
69.00	06900	5,059	0	0	0	23,055	69.00
69.01	06902	3,517	3,368	0	0	3,919	69.01
71.00	07100	0	0	44,081	0	58,616	71.00
72.00	07200	0	0	98,640	0	62,054	72.00
73.00	07300	0	0	0	766,137	38,293	73.00
74.00	07400	494	498	0	0	800	74.00
76.00	03020	0	0	0	0	6	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		79,035	69,571	142,721	766,137	513,202	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		79,035	69,571	142,721	766,137	513,202	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	198,111			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	192,458	6,229,940	0	6,229,940
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	2,138,013	0	2,138,013
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	140,870	0	140,870
59.00	05900	CARDIAC CATHETERIZATION	5,653	5,490,349	0	5,490,349
60.00	06000	LABORATORY	0	2,043,090	0	2,043,090
64.00	06400	INTRAVENOUS THERAPY	0	226,941	0	226,941
65.00	06500	RESPIRATORY THERAPY	0	517,025	0	517,025
66.00	06600	PHYSICAL THERAPY	0	54,965	0	54,965
69.00	06900	ELECTROCARDIOLOGY	0	349,378	0	349,378
69.01	06902	CARDIAC REHAB	0	440,240	0	440,240
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,645,106	0	4,645,106
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,925,005	0	9,925,005
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,662,878	0	2,662,878
74.00	07400	RENAL DIALYSIS	0	163,791	0	163,791
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	1,184	0	1,184
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	198,111	35,028,775	0	35,028,775
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	26,789	0	26,789
194.02	07952	PUBLIC RELATIONS	0	18,381	0	18,381
200.00		Cross Foot Adjustments		0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	198,111	35,073,945	0	35,073,945

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2013 7:56 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			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	57,089	73,048	130,137	5.00
7.00 00700	OPERATION OF PLANT	0	5,597	0	5,597	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	8,450	0	8,450	9.00
10.00 01000	DIETARY	0	0	0	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	992	992	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	786,470	151,243	937,713	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	255,982	372,524	628,506	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	539,227	581,449	1,120,676	59.00
60.00 06000	LABORATORY	0	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	314,511	314,511	69.00
69.01 06902	CARDIAC REHAB	0	0	83,511	83,511	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	36,369	36,369	74.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,652,815	1,613,647	3,266,462	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	VISITOR ASSISTANTS	0	0	0	0	194.01
194.02 07952	PUBLIC RELATIONS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,652,815	1,613,647	3,266,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 7:56 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>						
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	130,137			5.00
7.00	00700	OPERATION OF PLANT	1,910	7,507		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	314	0	314	8.00
9.00	00900	HOUSEKEEPING	755	40	0	9,245
10.00	01000	DIETARY	782	0	0	0
11.00	01100	CAFETERIA	293	0	0	0
13.00	01300	NURSING ADMINISTRATION	258	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	530	0	0	0
15.00	01500	PHARMACY	2,843	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,904	0	0	0
17.00	01700	SOCIAL SERVICE	735	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	19,698	3,713	192	4,597
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	7,254	1,208	38	1,496
54.00	05400	RADIOLOGY-DIAGNOSTIC	462	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	18,513	2,546	66	3,152
60.00	06000	LABORATORY	7,462	0	0	0
64.00	06400	INTRAVENOUS THERAPY	811	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,898	0	0	0
66.00	06600	PHYSICAL THERAPY	194	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,174	0	18	0
69.01	06902	CARDIAC REHAB	1,593	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,854	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,233	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,895	0	0	0
74.00	07400	RENAL DIALYSIS	601	0	0	0
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	4	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	129,970	7,507	314	9,245
<b>NONREIMBURSABLE COST CENTERS</b>						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.01	07951	VISITOR ASSISTANTS	99	0	0	0
194.02	07952	PUBLIC RELATIONS	68	0	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	130,137	7,507	314	9,245

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/27/2013 7:56 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	293					11.00
13.00	01300	0	1,250				13.00
14.00	01400	0	0	530			14.00
15.00	01500	0	0	0	2,843		15.00
16.00	01600	0	0	0	0	1,904	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	135	621	0	0	161	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	22	103	0	0	165	50.00
54.00	05400	3	0	0	0	57	54.00
59.00	05900	85	391	0	0	681	59.00
60.00	06000	0	0	0	0	118	60.00
64.00	06400	14	65	0	0	4	64.00
65.00	06500	0	0	0	0	20	65.00
66.00	06600	0	0	0	0	10	66.00
69.00	06900	19	0	0	0	85	69.00
69.01	06902	13	61	0	0	14	69.01
71.00	07100	0	0	163	0	216	71.00
72.00	07200	0	0	367	0	229	72.00
73.00	07300	0	0	0	2,843	141	73.00
74.00	07400	2	9	0	0	3	74.00
76.00	03020	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		293	1,250	530	2,843	1,904	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		293	1,250	530	2,843	1,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/27/2013 7:56 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	GENERAL SERVICE COST CENTERS	17.00	24.00	25.00	26.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DIETARY					10.00
11.00	01100 CAFETERIA					11.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
17.00	01700 SOCIAL SERVICE	735				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	714	968,304	0	968,304	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	638,792	0	638,792	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	522	0	522	54.00
59.00	05900 CARDIAC CATHETERIZATION	21	1,146,153	0	1,146,153	59.00
60.00	06000 LABORATORY	0	7,580	0	7,580	60.00
64.00	06400 INTRAVENOUS THERAPY	0	894	0	894	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,918	0	1,918	65.00
66.00	06600 PHYSICAL THERAPY	0	204	0	204	66.00
69.00	06900 ELECTROCARDIOLOGY	0	315,807	0	315,807	69.00
69.01	06902 CARDIAC REHAB	0	85,192	0	85,192	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,233	0	17,233	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	36,829	0	36,829	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,879	0	9,879	73.00
74.00	07400 RENAL DIALYSIS	0	36,984	0	36,984	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	4	0	4	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	735	3,266,295	0	3,266,295	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951 VISITOR ASSISTANTS	0	99	0	99	194.01
194.02	07952 PUBLIC RELATIONS	0	68	0	68	194.02
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	735	3,266,462	0	3,266,462	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DEPRECIATION COST)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	45,772					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		463,739				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	7,189,853			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,581	20,993	474,330	-4,547,081	30,526,864	5.00
7.00 00700	OPERATION OF PLANT	155	0	0	0	448,087	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	73,750	8.00
9.00 00900	HOUSEKEEPING	234	0	0	0	177,134	9.00
10.00 01000	DIETARY	0	0	0	0	183,517	10.00
11.00 01100	CAFETERIA	0	0	0	0	68,789	11.00
13.00 01300	NURSING ADMINISTRATION	0	285	0	0	60,552	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	124,218	14.00
15.00 01500	PHARMACY	0	0	0	0	666,813	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	446,669	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	172,427	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	21,780	43,465	2,887,574	0	4,620,786	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	7,089	107,058	538,476	0	1,701,617	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	80,005	0	108,464	54.00
59.00 05900	CARDIAC CATHETERIZATION	14,933	167,100	2,176,118	0	4,342,675	59.00
60.00 06000	LABORATORY	0	0	0	0	1,750,463	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	376,651	0	190,154	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	445,281	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	45,593	66.00
69.00 06900	ELECTROCARDIOLOGY	0	90,386	378,637	0	275,310	69.00
69.01 06902	CARDIAC REHAB	0	24,000	221,262	0	373,763	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,953,520	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,498,432	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,617,514	73.00
74.00 07400	RENAL DIALYSIS	0	10,452	56,800	0	140,997	74.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	1,025	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	45,772	463,739	7,189,853	-4,547,081	30,487,550	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07951	VISITOR ASSISTANTS	0	0	0	0	23,316	194.01
194.02 07952	PUBLIC RELATIONS	0	0	0	0	15,998	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,652,815	1,613,647	1,588,982		4,547,081	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	36.109740	3.479645	0.221003		0.148953	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		130,137	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004263	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	44,036				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,448			8.00
9.00	00900	HOUSEKEEPING	234	0	43,802		9.00
10.00	01000	DIETARY	0	0	0	21,029	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	21,780	87,547	21,780	20,429	590
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,089	17,581	7,089	0	97
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	13
59.00	05900	CARDIAC CATHETERIZATION	14,933	29,947	14,933	600	372
60.00	06000	LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	62
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	8,373	0	0	82
69.01	06902	CARDIAC REHAB	0	0	0	0	57
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	8
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,036	143,448	43,802	21,029	1,281
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	514,831	84,735	206,255	210,852	79,035
203.00		Unit cost multiplier (Wkst. B, Part I)	11.691139	0.590702	4.708803	10.026725	61.697892
204.00		Cost to be allocated (per Wkst. B, Part II)	7,507	314	9,245	782	293
205.00		Unit cost multiplier (Wkst. B, Part II)	0.170474	0.002189	0.211063	0.037187	0.228728

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	246,604					13.00
14.00	01400	0	12,296,240				14.00
15.00	01500	0	0	1,617,514			15.00
16.00	01600	0	0	0	135,231,227		16.00
17.00	01700	0	0	0	0	7,149	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	122,670	0	0	11,506,674	6,945	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	20,239	0	0	11,751,223	0	50.00
54.00	05400	0	0	0	4,070,647	0	54.00
59.00	05900	77,174	0	0	47,915,118	204	59.00
60.00	06000	0	0	0	8,403,055	0	60.00
64.00	06400	12,818	0	0	269,429	0	64.00
65.00	06500	0	0	0	1,427,592	0	65.00
66.00	06600	0	0	0	680,190	0	66.00
69.00	06900	0	0	0	6,075,097	0	69.00
69.01	06902	11,937	0	0	1,032,584	0	69.01
71.00	07100	0	3,797,808	0	15,445,469	0	71.00
72.00	07200	0	8,498,432	0	16,351,540	0	72.00
73.00	07300	0	0	1,617,514	10,090,428	0	73.00
74.00	07400	1,766	0	0	210,729	0	74.00
76.00	03020	0	0	0	1,452	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		246,604	12,296,240	1,617,514	135,231,227	7,149	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		69,571	142,721	766,137	513,202	198,111	202.00
203.00		0.282116	0.011607	0.473651	0.003795	27.711708	203.00
204.00		1,250	530	2,843	1,904	735	204.00
205.00		0.005069	0.000043	0.001758	0.000014	0.102812	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	6,229,940		6,229,940	0	6,229,940	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,138,013		2,138,013	0	2,138,013	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	140,870		140,870	0	140,870	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,490,349		5,490,349	0	5,490,349	59.00
60.00	06000 LABORATORY	2,043,090		2,043,090	0	2,043,090	60.00
64.00	06400 INTRAVENOUS THERAPY	226,941		226,941	0	226,941	64.00
65.00	06500 RESPIRATORY THERAPY	517,025	0	517,025	0	517,025	65.00
66.00	06600 PHYSICAL THERAPY	54,965	0	54,965	0	54,965	66.00
69.00	06900 ELECTROCARDIOLOGY	349,378		349,378	0	349,378	69.00
69.01	06902 CARDIAC REHAB	440,240		440,240	0	440,240	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,645,106		4,645,106	0	4,645,106	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,925,005		9,925,005	0	9,925,005	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,662,878		2,662,878	0	2,662,878	73.00
74.00	07400 RENAL DIALYSIS	163,791		163,791	483	164,274	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	1,184		1,184	0	1,184	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	660,022		660,022		660,022	92.00
200.00	Subtotal (see instructions)	35,688,797	0	35,688,797	483	35,689,280	200.00
201.00	Less Observation Beds	660,022		660,022		660,022	201.00
202.00	Total (see instructions)	35,028,775	0	35,028,775	483	35,029,258	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,649,367		10,649,367			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,445,220	306,003	11,751,223	0.181940	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,904,640	2,166,007	4,070,647	0.034606	0.000000	54.00
59.00	05900 CARDIAC CATHETERIZATION	16,164,830	31,750,288	47,915,118	0.114585	0.000000	59.00
60.00	06000 LABORATORY	6,921,149	1,481,906	8,403,055	0.243137	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	231,290	38,139	269,429	0.842304	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,410,995	16,597	1,427,592	0.362166	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	670,330	9,860	680,190	0.080808	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	1,911,181	4,163,915	6,075,096	0.057510	0.000000	69.00
69.01	06902 CARDIAC REHAB	169	1,032,415	1,032,584	0.426348	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,890,311	5,555,158	15,445,469	0.300742	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,262,202	11,089,337	16,351,539	0.606977	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,692,908	2,397,520	10,090,428	0.263901	0.000000	73.00
74.00	07400 RENAL DIALYSIS	206,380	4,349	210,729	0.777259	0.000000	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	872	581	1,453	0.814866	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	136,353	720,955	857,308	0.769877	0.000000	92.00
200.00	Subtotal (see instructions)	74,498,197	60,733,030	135,231,227			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	74,498,197	60,733,030	135,231,227			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.181940			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.034606			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.114585			59.00
60.00	06000 LABORATORY	0.243137			60.00
64.00	06400 INTRAVENOUS THERAPY	0.842304			64.00
65.00	06500 RESPIRATORY THERAPY	0.362166			65.00
66.00	06600 PHYSICAL THERAPY	0.080808			66.00
69.00	06900 ELECTROCARDIOLOGY	0.057510			69.00
69.01	06902 CARDIAC REHAB	0.426348			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300742			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.606977			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263901			73.00
74.00	07400 RENAL DIALYSIS	0.779551			74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.814866			76.00
	OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769877			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	6,229,940		6,229,940	0	6,229,940	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,138,013		2,138,013	0	2,138,013	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	140,870		140,870	0	140,870	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,490,349		5,490,349	0	5,490,349	59.00
60.00	06000 LABORATORY	2,043,090		2,043,090	0	2,043,090	60.00
64.00	06400 INTRAVENOUS THERAPY	226,941		226,941	0	226,941	64.00
65.00	06500 RESPIRATORY THERAPY	517,025	0	517,025	0	517,025	65.00
66.00	06600 PHYSICAL THERAPY	54,965	0	54,965	0	54,965	66.00
69.00	06900 ELECTROCARDIOLOGY	349,378		349,378	0	349,378	69.00
69.01	06902 CARDIAC REHAB	440,240		440,240	0	440,240	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,645,106		4,645,106	0	4,645,106	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,925,005		9,925,005	0	9,925,005	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,662,878		2,662,878	0	2,662,878	73.00
74.00	07400 RENAL DIALYSIS	163,791		163,791	483	164,274	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	1,184		1,184	0	1,184	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	660,022		660,022		660,022	92.00
200.00	Subtotal (see instructions)	35,688,797	0	35,688,797	483	35,689,280	200.00
201.00	Less Observation Beds	660,022		660,022		660,022	201.00
202.00	Total (see instructions)	35,028,775	0	35,028,775	483	35,029,258	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,649,367		10,649,367			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,445,220	306,003	11,751,223	0.181940	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,904,640	2,166,007	4,070,647	0.034606	0.000000	54.00
59.00	05900 CARDIAC CATHETERIZATION	16,164,830	31,750,288	47,915,118	0.114585	0.000000	59.00
60.00	06000 LABORATORY	6,921,149	1,481,906	8,403,055	0.243137	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	231,290	38,139	269,429	0.842304	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,410,995	16,597	1,427,592	0.362166	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	670,330	9,860	680,190	0.080808	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	1,911,181	4,163,915	6,075,096	0.057510	0.000000	69.00
69.01	06902 CARDIAC REHAB	169	1,032,415	1,032,584	0.426348	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,890,311	5,555,158	15,445,469	0.300742	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,262,202	11,089,337	16,351,539	0.606977	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,692,908	2,397,520	10,090,428	0.263901	0.000000	73.00
74.00	07400 RENAL DIALYSIS	206,380	4,349	210,729	0.777259	0.000000	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	872	581	1,453	0.814866	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	136,353	720,955	857,308	0.769877	0.000000	92.00
200.00	Subtotal (see instructions)	74,498,197	60,733,030	135,231,227			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	74,498,197	60,733,030	135,231,227			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.181940			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.034606			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.114585			59.00
60.00	06000 LABORATORY	0.243137			60.00
64.00	06400 INTRAVENOUS THERAPY	0.842304			64.00
65.00	06500 RESPIRATORY THERAPY	0.362166			65.00
66.00	06600 PHYSICAL THERAPY	0.080808			66.00
69.00	06900 ELECTROCARDIOLOGY	0.057510			69.00
69.01	06902 CARDIAC REHAB	0.426348			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300742			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.606977			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263901			73.00
74.00	07400 RENAL DIALYSIS	0.779551			74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.814866			76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769877			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 150175

Period: From 10/01/2011 To 09/30/2012

Worksheet C Part II Date/Time Prepared: 2/27/2013 7:56 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,138,013	638,792	1,499,221	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	140,870	522	140,348	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,490,349	1,146,153	4,344,196	0	0	59.00
60.00	06000 LABORATORY	2,043,090	7,580	2,035,510	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	226,941	894	226,047	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	517,025	1,918	515,107	0	0	65.00
66.00	06600 PHYSICAL THERAPY	54,965	204	54,761	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	349,378	315,807	33,571	0	0	69.00
69.01	06902 CARDIAC REHAB	440,240	85,192	355,048	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,645,106	17,233	4,627,873	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,925,005	36,829	9,888,176	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,662,878	9,879	2,652,999	0	0	73.00
74.00	07400 RENAL DIALYSIS	163,791	36,984	126,807	0	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	1,184	4	1,180	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	660,022	102,586	557,436	0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	29,458,857	2,400,577	27,058,280	0	0	200.00
201.00	Less Observation Beds	660,022	102,586	557,436	0	0	201.00
202.00	Total (line 200 minus line 201)	28,798,835	2,297,991	26,500,844	0	0	202.00

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

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part II  
Date/Time Prepared:  
2/27/2013 7:56 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)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2,138,013	11,751,223	0.181940	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	140,870	4,070,647	0.034606	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,490,349	47,915,118	0.114585	59.00
60.00	06000 LABORATORY	2,043,090	8,403,055	0.243137	60.00
64.00	06400 INTRAVENOUS THERAPY	226,941	269,429	0.842304	64.00
65.00	06500 RESPIRATORY THERAPY	517,025	1,427,592	0.362166	65.00
66.00	06600 PHYSICAL THERAPY	54,965	680,190	0.080808	66.00
69.00	06900 ELECTROCARDIOLOGY	349,378	6,075,096	0.057510	69.00
69.01	06902 CARDIAC REHAB	440,240	1,032,584	0.426348	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,645,106	15,445,469	0.300742	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,925,005	16,351,539	0.606977	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,662,878	10,090,428	0.263901	73.00
74.00	07400 RENAL DIALYSIS	163,791	210,729	0.777259	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	1,184	1,453	0.814866	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	660,022	857,308	0.769877	92.00
200.00	Subtotal (sum of lines 50 thru 199)	29,458,857	124,581,860		200.00
201.00	Less Observation Beds	660,022	0		201.00
202.00	Total (line 200 minus line 201)	28,798,835	124,581,860		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	6,229,940		6,229,940	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,138,013		2,138,013	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	140,870		140,870	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	5,490,349		5,490,349	0	0	59.00
60.00	06000 LABORATORY	2,043,090		2,043,090	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	226,941		226,941	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	517,025	0	517,025	0	0	65.00
66.00	06600 PHYSICAL THERAPY	54,965	0	54,965	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	349,378		349,378	0	0	69.00
69.01	06902 CARDIAC REHAB	440,240		440,240	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,645,106		4,645,106	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,925,005		9,925,005	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,662,878		2,662,878	0	0	73.00
74.00	07400 RENAL DIALYSIS	163,791		163,791	0	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	1,184		1,184	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	660,022		660,022	0	0	92.00
200.00	Subtotal (see instructions)	35,688,797	0	35,688,797	0	0	200.00
201.00	Less Observation Beds	660,022		660,022			201.00
202.00	Total (see instructions)	35,028,775	0	35,028,775	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,649,367		10,649,367			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,445,220	306,003	11,751,223	0.181940	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,904,640	2,166,007	4,070,647	0.034606	0.000000	54.00
59.00	05900 CARDIAC CATHETERIZATION	16,164,830	31,750,288	47,915,118	0.114585	0.000000	59.00
60.00	06000 LABORATORY	6,921,149	1,481,906	8,403,055	0.243137	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	231,290	38,139	269,429	0.842304	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,410,995	16,597	1,427,592	0.362166	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	670,330	9,860	680,190	0.080808	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	1,911,181	4,163,915	6,075,096	0.057510	0.000000	69.00
69.01	06902 CARDIAC REHAB	169	1,032,415	1,032,584	0.426348	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,890,311	5,555,158	15,445,469	0.300742	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5,262,202	11,089,337	16,351,539	0.606977	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,692,908	2,397,520	10,090,428	0.263901	0.000000	73.00
74.00	07400 RENAL DIALYSIS	206,380	4,349	210,729	0.777259	0.000000	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	872	581	1,453	0.814866	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	136,353	720,955	857,308	0.769877	0.000000	92.00
200.00	Subtotal (see instructions)	74,498,197	60,733,030	135,231,227			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	74,498,197	60,733,030	135,231,227			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		PPS Inpatient Ratio	Title V	Hospital
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06902 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 7:56 pm	
Cost Center Description			Title XVII		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	03000	ADULTS & PEDIATRICS	968,304	0	968,304	6,881	140.72	30.00
200.00		Total (lines 30-199)	968,304		968,304	6,881		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 7:56 pm	
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,508	493,646				30.00
200.00		Total (lines 30-199)	3,508	493,646				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/27/2013 7:56 pm			
Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	638,792	11,751,223	0.054360	5,685,917	309,086	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	522	4,070,647	0.000128	979,283	125	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,146,153	47,915,118	0.023920	7,804,171	186,676	59.00
60.00	06000	LABORATORY	7,580	8,403,055	0.000902	4,165,167	3,757	60.00
64.00	06400	INTRAVENOUS THERAPY	894	269,429	0.003318	91,051	302	64.00
65.00	06500	RESPIRATORY THERAPY	1,918	1,427,592	0.001344	723,542	972	65.00
66.00	06600	PHYSICAL THERAPY	204	680,190	0.000300	495,188	149	66.00
69.00	06900	ELECTROCARDIOLOGY	315,807	6,075,096	0.051984	1,019,645	53,005	69.00
69.01	06902	CARDIAC REHAB	85,192	1,032,584	0.082504	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,233	15,445,469	0.001116	5,022,950	5,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,829	16,351,539	0.002252	2,797,530	6,300	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,879	10,090,428	0.000979	4,124,702	4,038	73.00
74.00	07400	RENAL DIALYSIS	36,984	210,729	0.175505	130,067	22,827	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	4	1,453	0.002753	581	2	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	102,586	857,308	0.119661	101,146	12,103	92.00
200.00		Total (Lines 50-199)	2,400,577	124,581,860		33,140,940	604,948	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 7:56 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 7:56 pm	
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)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,881	0.00	3,508	0	30.00	
200.00		Total (lines 30-199)	6,881		3,508	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:56 pm
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Cost Center Description	Title XVIII				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06902 CARDIAC REHAB	0	0	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2013 7:56 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			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	11,751,223	0.000000	0.000000	5,685,917	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,070,647	0.000000	0.000000	979,283	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	47,915,118	0.000000	0.000000	7,804,171	59.00
60.00	06000	LABORATORY	0	8,403,055	0.000000	0.000000	4,165,167	60.00
64.00	06400	INTRAVENOUS THERAPY	0	269,429	0.000000	0.000000	91,051	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,427,592	0.000000	0.000000	723,542	65.00
66.00	06600	PHYSICAL THERAPY	0	680,190	0.000000	0.000000	495,188	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,075,096	0.000000	0.000000	1,019,645	69.00
69.01	06902	CARDIAC REHAB	0	1,032,584	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,445,469	0.000000	0.000000	5,022,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,351,539	0.000000	0.000000	2,797,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,090,428	0.000000	0.000000	4,124,702	73.00
74.00	07400	RENAL DIALYSIS	0	210,729	0.000000	0.000000	130,067	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	1,453	0.000000	0.000000	581	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	857,308	0.000000	0.000000	101,146	92.00
200.00		Total (Lines 50-199)	0	124,581,860			33,140,940	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:56 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	117,741	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	736,914	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	13,210,605	0	59.00
60.00	06000 LABORATORY	0	17,312	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	7,224	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	9,298	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,121,611	0	69.00
69.01	06902 CARDIAC REHAB	0	533,896	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,517,915	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,114,804	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	978,195	0	73.00
74.00	07400 RENAL DIALYSIS	0	2,994	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	252,036	0	92.00
200.00	Total (Lines 50-199)	0	25,620,545	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 7:56 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		1.00	2.00	3.00				
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.181940	117,741	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.034606	736,914	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.114585	13,210,605	0	9,880		59.00
60.00	06000	LABORATORY	0.243137	17,312	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0.842304	7,224	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0.362166	9,298	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.080808	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.057510	1,121,611	0	0		69.00
69.01	06902	CARDIAC REHAB	0.426348	533,896	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300742	2,517,915	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.606977	6,114,804	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263901	978,195	0	38,808		73.00
74.00	07400	RENAL DIALYSIS	0.777259	2,994	0	0		74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.814866	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769877	252,036	0	0		92.00
200.00		Subtotal (see instructions)		25,620,545	0	48,688		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		25,620,545	0	48,688		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 7:56 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS
	PPS Services (see inst.)	Cost	Cost		
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
5.00	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	21,422	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	25,502	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	1,513,737	0	1,132	59.00
60.00	06000 LABORATORY	4,209	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	6,085	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,367	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	64,504	0	0	69.00
69.01	06902 CARDIAC REHAB	227,625	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	757,243	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,711,545	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	258,147	0	10,241	73.00
74.00	07400 RENAL DIALYSIS	2,327	0	0	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	194,037	0	0	92.00
200.00	Subtotal (see instructions)	6,789,750	0	11,373	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	6,789,750	0	11,373	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 7:56 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	03000	ADULTS & PEDIATRICS	968,304	0	968,304	6,881	140.72	30.00
200.00		Total (lines 30-199)	968,304		968,304	6,881		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/27/2013 7:56 pm	
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	PPS	
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	232	32,647				30.00
200.00		Total (lines 30-199)	232	32,647				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/27/2013 7:56 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	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	638,792	11,751,223	0.054360	353,759	19,230	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	522	4,070,647	0.000128	85,864	11	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,146,153	47,915,118	0.023920	475,783	11,381	59.00
60.00	06000	LABORATORY	7,580	8,403,055	0.000902	295,140	266	60.00
64.00	06400	INTRAVENOUS THERAPY	894	269,429	0.003318	16,438	55	64.00
65.00	06500	RESPIRATORY THERAPY	1,918	1,427,592	0.001344	115,119	155	65.00
66.00	06600	PHYSICAL THERAPY	204	680,190	0.000300	22,498	7	66.00
69.00	06900	ELECTROCARDIOLOGY	315,807	6,075,096	0.051984	53,055	2,758	69.00
69.01	06902	CARDIAC REHAB	85,192	1,032,584	0.082504	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,233	15,445,469	0.001116	285,698	319	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	36,829	16,351,539	0.002252	183,056	412	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,879	10,090,428	0.000979	361,466	354	73.00
74.00	07400	RENAL DIALYSIS	36,984	210,729	0.175505	52,982	9,299	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	4	1,453	0.002753	290	1	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	102,586	857,308	0.119661	6,012	719	92.00
200.00		Total (Lines 50-199)	2,400,577	124,581,860		2,307,160	44,967	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 7:56 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/27/2013 7:56 pm	
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)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,881	0.00	232	0	30.00	
200.00		Total (lines 30-199)	6,881		232	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:56 pm
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06902	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/27/2013 7:56 pm
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Cost Center Description		Title XIX			Hospital		Inpatient Program Charges	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	11,751,223	0.000000	0.000000	353,759	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,070,647	0.000000	0.000000	85,864	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	47,915,118	0.000000	0.000000	475,783	59.00
60.00	06000	LABORATORY	0	8,403,055	0.000000	0.000000	295,140	60.00
64.00	06400	INTRAVENOUS THERAPY	0	269,429	0.000000	0.000000	16,438	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,427,592	0.000000	0.000000	115,119	65.00
66.00	06600	PHYSICAL THERAPY	0	680,190	0.000000	0.000000	22,498	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,075,096	0.000000	0.000000	53,055	69.00
69.01	06902	CARDIAC REHAB	0	1,032,584	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,445,469	0.000000	0.000000	285,698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,351,539	0.000000	0.000000	183,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,090,428	0.000000	0.000000	361,466	73.00
74.00	07400	RENAL DIALYSIS	0	210,729	0.000000	0.000000	52,982	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	1,453	0.000000	0.000000	290	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	857,308	0.000000	0.000000	6,012	92.00
200.00		Total (lines 50-199)	0	124,581,860			2,307,160	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2013 7:56 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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06902 CARDIAC REHAB	0	0	0		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part V  
Date/Time Prepared:  
2/27/2013 7:56 pm

		Title XIX		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.181940	0	0	5,189		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.034606	0	0	58,375		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.114585	0	0	772,047		59.00
60.00	06000	LABORATORY	0.243137	0	0	55,310		60.00
64.00	06400	INTRAVENOUS THERAPY	0.842304	0	0	919		64.00
65.00	06500	RESPIRATORY THERAPY	0.362166	0	0	222		65.00
66.00	06600	PHYSICAL THERAPY	0.080808	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.057510	0	0	132,883		69.00
69.01	06902	CARDIAC REHAB	0.426348	0	0	12,168		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300742	0	0	122,804		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.606977	0	0	217,540		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263901	0	0	77,009		73.00
74.00	07400	RENAL DIALYSIS	0.777259	0	0	0		74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.814866	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769877	0	0	43,648		92.00
200.00		Subtotal (see instructions)		0	0	1,498,114		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	1,498,114		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/27/2013 7:56 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	944	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,020	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	88,465	59.00
60.00	06000	LABORATORY	0	0	13,448	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	774	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	80	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,642	69.00
69.01	06902	CARDIAC REHAB	0	0	5,188	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	36,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	132,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	20,323	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	33,604	92.00
200.00		Subtotal (see instructions)	0	0	341,462	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	341,462	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/27/2013 7:56 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,881	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,881	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,152	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,508	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,229,940	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)		6,229,940	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		10,649,367	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		10,649,367	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.585006	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,731.04	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,229,940	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		905.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,176,073	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,176,073	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 7:56 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,889,620 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,065,693 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)					493,646 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					604,948 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,098,594 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,967,099 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)					729 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					905.38 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					660,022 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:56 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	968,304	6,229,940	0.155428	660,022	102,586	90.00
91.00	Nursing School cost	0	6,229,940	0.000000	660,022	0	91.00
92.00	Allied health cost	0	6,229,940	0.000000	660,022	0	92.00
93.00	All other Medical Education	0	6,229,940	0.000000	660,022	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/27/2013 7:56 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,881	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,881	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,152	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)		232	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,229,940	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)		6,229,940	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,229,940	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		905.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		210,048	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)		210,048	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/27/2013 7:56 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)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				592,608 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				802,656 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)				32,647 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				44,967 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				77,614 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				725,042 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)				729 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				905.38 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				660,022 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/27/2013 7:56 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	968,304	6,229,940	0.155428	660,022	102,586	90.00
91.00	Nursing School cost	0	6,229,940	0.000000	660,022	0	91.00
92.00	Allied health cost	0	6,229,940	0.000000	660,022	0	92.00
93.00	All other Medical Education	0	6,229,940	0.000000	660,022	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:56 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		5,497,376		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.181940	5,685,917	1,034,496	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.034606	979,283	33,889	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.114585	7,804,171	894,241	59.00
60.00	06000 LABORATORY	0.243137	4,165,167	1,012,706	60.00
64.00	06400 INTRAVENOUS THERAPY	0.842304	91,051	76,693	64.00
65.00	06500 RESPIRATORY THERAPY	0.362166	723,542	262,042	65.00
66.00	06600 PHYSICAL THERAPY	0.080808	495,188	40,015	66.00
69.00	06900 ELECTROCARDIOLOGY	0.057510	1,019,645	58,640	69.00
69.01	06902 CARDIAC REHAB	0.426348	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300742	5,022,950	1,510,612	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.606977	2,797,530	1,698,036	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263901	4,124,702	1,088,513	73.00
74.00	07400 RENAL DIALYSIS	0.779551	130,067	101,394	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.814866	581	473	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769877	101,146	77,870	92.00
200.00	Total (sum of lines 50-94 and 96-98)		33,140,940	7,889,620	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)		33,140,940		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/27/2013 7:56 pm
		Title XIX	Hospital	PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		423,698		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.181940	353,759	64,363	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.034606	85,864	2,971	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.114585	475,783	54,518	59.00
60.00	06000 LABORATORY	0.243137	295,140	71,759	60.00
64.00	06400 INTRAVENOUS THERAPY	0.842304	16,438	13,846	64.00
65.00	06500 RESPIRATORY THERAPY	0.362166	115,119	41,692	65.00
66.00	06600 PHYSICAL THERAPY	0.080808	22,498	1,818	66.00
69.00	06900 ELECTROCARDIOLOGY	0.057510	53,055	3,051	69.00
69.01	06902 CARDIAC REHAB	0.426348	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300742	285,698	85,921	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.606977	183,056	111,111	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263901	361,466	95,391	73.00
74.00	07400 RENAL DIALYSIS	0.779551	52,982	41,302	74.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.814866	290	236	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.769877	6,012	4,629	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,307,160	592,608	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)		2,307,160		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 7:56 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		9,216,321	1.00
2.00	Outlier payments for discharges. (see instructions)		174,076	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)		22.01	4.00
<b>Indirect Medical Education Adjustment</b>				
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
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)		9,390,397	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/27/2013 7:56 pm
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	9,390,397		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	788,615		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
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)	10,179,012		59.00
60.00	Primary payer payments	1,288		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,177,724		61.00
62.00	Deductibles billed to program beneficiaries	722,080		62.00
63.00	Coinsurance billed to program beneficiaries	12,084		63.00
64.00	Allowable bad debts (see instructions)	20,544		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	14,381		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,813		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,457,941		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
70.95	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)	9,457,941		71.00
72.00	Interim payments	9,443,559		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)	14,382		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/27/2013 7:56 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			11,373 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			6,789,750 2.00
3.00	PPS payments			7,302,636 3.00
4.00	Outlier payment (see instructions)			193,092 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			11,373 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			48,688 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)			48,688 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			48,688 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			37,315 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			11,373 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)			7,495,728 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			991,964 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)			6,515,137 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)			6,515,137 30.00
31.00	Primary payer payments			34 31.00
32.00	Subtotal (line 30 minus line 31)			6,515,103 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			61,879 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			43,315 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			47,969 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			6,558,418 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			6,558,418 40.00
41.00	Interim payments			6,505,711 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)			52,707 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 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: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2013 7:56 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		9,443,559		6,505,711	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)		9,443,559		6,505,711	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		14,382		52,707	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,457,941		6,558,418	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part II  
Date/Time Prepared:  
2/27/2013 7:56 pm

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,697 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,508 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			652 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			6,152 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			135,231,227 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,455,300 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,089,728 8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,057,428 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			32,300 32.00

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

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G  
Date/Time Prepared:  
2/27/2013 7:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,974,496	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	15,864,722	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,791,397	0	0	0	6.00
7.00	Inventory	765,570	0	0	0	7.00
8.00	Prepaid expenses	81,248	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)	9,894,639	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,969,078	0	0	0	19.00
20.00	Accumulated depreciation	-2,785,917	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)	3,183,161	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,658,815	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,658,815	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,736,615	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	674,444	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,130,211	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,804,655	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,804,655	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	13,931,960				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)	13,931,960	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,736,615	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/27/2013 7:56 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		15,523,891		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		13,303,182			2.00
3.00	Total (sum of line 1 and line 2)		28,827,073		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		28,827,073		0	11.00
12.00	DISTRIBUTIONS TO MEMBERS	14,895,113		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)		14,895,113		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,931,960		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/27/2013 7:56 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
			0		0	
2.00						2.00
3.00			0		0	3.00
4.00						4.00
	0			0		
5.00	0			0		5.00
	0			0		
6.00	0			0		6.00
	0			0		
7.00	0			0		7.00
	0			0		
8.00	0			0		8.00
	0			0		
9.00	0			0		9.00
			0		0	
10.00			0		0	10.00
			0		0	
11.00						11.00
	0			0		
12.00	0			0		12.00
	0			0		
13.00	0			0		13.00
	0			0		
14.00	0			0		14.00
	0			0		
15.00	0			0		15.00
	0			0		
16.00	0			0		16.00
	0			0		
17.00	0			0		17.00
			0		0	
18.00			0		0	18.00
			0		0	
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2013 7:56 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	10,910,479		10,910,479	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,910,479		10,910,479	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,910,479		10,910,479	17.00
18.00	Ancillary services	67,053,551	60,928,682	127,982,233	18.00
19.00	Outpatient services	0	733,788	733,788	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	77,964,030	61,662,470	139,626,500	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,265,035		29.00
30.00	BAD DEBT	1,537,873			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)		1,537,873		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		39,802,908		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-3

Date/Time Prepared:  
2/27/2013 7:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	139,626,500	1.00
2.00	Less contractual allowances and discounts on patients' accounts	87,855,228	2.00
3.00	Net patient revenues (line 1 minus line 2)	51,771,272	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,802,908	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,968,364	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,435	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,333,384	24.00
25.00	Total other income (sum of lines 6-24)	1,334,819	25.00
26.00	Total (line 5 plus line 25)	13,303,183	26.00
27.00	ROUNDING VARIANCE	1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,303,182	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 150175

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet 1-5

Date/Time Prepared:  
2/27/2013 7:56 pm

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

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150175	Period: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/27/2013 7:56 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		735,899	1.00
2.00	Capital DRG outlier payments		52,716	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.98	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)		788,615	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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