

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012 Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 6:50 pm

PART I - COST REPORT STATUS		
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2013 Time: 6:50 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL LOGANSPORT (150072) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	110,320	-157,302	39,490	-300,900	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	110,320	-157,302	39,490	-300,900	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: 150072		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 6:41 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1101 MICHIGAN AVENUE		PO Box:						1.00		
2.00	City: LOGANSPO RT		State: IN		Zip Code: 46947-		County: CASS		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		MEMORIAL HOSPITAL LOGANSPO RT	150072	99915	1	07/01/1966	N	P	O	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		SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012		12/31/2012		20.00	
21.00	Type of Control (see instructions)							9		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	561	0	0	0	1,136	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		
						Urban/Rural	S	Date of Geogr			
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			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.					2			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.					1			35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 6:41 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.	01/01/2012	12/31/2012	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.	Y	Y	39.00		
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	

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

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

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

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

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V		XIX		
		1.00		2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical		Occupational		
		1.00		2.00		
		Speech		Respiratory		
		3.00		4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		109.00
		1.00		2.00		3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N				0
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:	492,234	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	Y	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

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							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 6:41 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)	N			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	05/17/2013	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		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/08/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 6:41 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/08/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 150072

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2013 6:41 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Title V		
	1.00	2.00	3.00	4.00	5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	77	28,182	0.00	0	1.00	
2.00 HMO						2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,182	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	0.00	0	8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY	43.00				0	13.00	
14.00 Total (see instructions)		83	30,378	0.00	0	14.00	
15.00 CAH visits					0	15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00	
18.00 SUBPROVIDER	42.00	0	0		0	18.00	
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
25.00 CMHC - CMHC						25.00	
25.10 CMHC - CORF	99.10				0	25.10	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)		83				27.00	
28.00 Observation Bed Days					0	28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
33.00 LTCH non-covered days						33.00	
				I/P Days / O/P Vi s i t s / Tri ps		Full Time Equivalents	
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2,883	410	5,666			1.00	
2.00 HMO	326	1,136				2.00	
3.00 HMO IPF Subprovider	0	0				3.00	
4.00 HMO IRF Subprovider	0	0				4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,883	410	5,666			7.00	
8.00 INTENSIVE CARE UNIT	460	0	644			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		151	1,166			13.00	
14.00 Total (see instructions)	3,343	561	7,476	0.00	494.44	14.00	
15.00 CAH visits	0	0	0			15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00	
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00	
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
25.00 CMHC - CMHC						25.00	
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150072

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2013 6:41 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	494.44	27.00
28.00	Observation Bed Days		280	1,467			28.00
29.00	Ambulance Trips	5,444					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
		11.00	12.00	13.00	14.00		15.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	872	218	1,983	1.00
2.00	HMO			90			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	872	218	1,983	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150072		Period: From 01/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/29/2013 6:41 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	26,549,689	0	26,549,689	1,018,125.00	26.08	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		92,635	0	92,635	1,015.00	91.27	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		1,616,872	0	1,616,872	16,651.00	97.10	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)		7,210,410	0	7,210,410	177,612.00	40.60	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		496,504	0	496,504	9,627.00	51.57	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		153,078	0	153,078	1,602.00	95.55	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
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		5,517,736	0	5,517,736			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		1,169,015	0	1,169,015			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		6,679	0	6,679			22.00
22.01	Physician Part A - Teaching		7,704	0	7,704			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
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	234,577	0	234,577	8,374.00	28.01	26.00
27.00	Administrative & General	5.00	2,610,291	0	2,610,291	122,611.00	21.29	27.00
28.00	Administrative & General under contract (see inst.)		254,923	0	254,923	1,313.00	194.15	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	469,891	0	469,891	20,819.00	22.57	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	497,854	0	497,854	41,917.00	11.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	645,994	-427,737	218,257	19,273.00	11.32	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	427,737	427,737	38,801.00	11.02	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	449,992	0	449,992	10,638.00	42.30	38.00
39.00	Central Services and Supply	14.00	162,852	0	162,852	10,902.00	14.94	39.00
40.00	Pharmacy	15.00	395,925	0	395,925	12,474.00	31.74	40.00
41.00	Medical Records & Medical Records Library	16.00	522,272	0	522,272	30,956.00	16.87	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150072

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2013 6:41 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	278,224	0	278,224	10,046.00	27.70	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150072

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2013 6:41 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	25,187,740	0	25,187,740	1,002,787.00	25.12	1.00
2.00	Excluded area salaries (see instructions)	7,210,410	0	7,210,410	177,612.00	40.60	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,977,330	0	17,977,330	825,175.00	21.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	649,582	0	649,582	11,229.00	57.85	4.00
5.00	Subtotal wage-related costs (see inst.)	5,524,415	0	5,524,415	0.00	30.73	5.00
6.00	Total (sum of lines 3 thru 5)	24,151,327	0	24,151,327	836,404.00	28.88	6.00
7.00	Total overhead cost (see instructions)	6,522,795	0	6,522,795	328,124.00	19.88	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2013 6:41 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 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)		705,169	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,389,500	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		139,321	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		47,325	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		240,846	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		185,367	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,768,804	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		73,384	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		83,333	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,633,049	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		68,086	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150072

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

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	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
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/29/2013 6:41 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.282370	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,648,196	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		21,615,088	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,103,452	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)		455,256	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		455,256	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,603,761	0	2,603,761	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	735,224	0	735,224	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	735,224	0	735,224	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)		6,834,274	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		33,839	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		6,800,435	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,920,239	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,655,463	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,110,719	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150072

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

Worksheet A
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		3,650,689		3,650,689	1.00
1.01	00101	MOB		252,874		252,874	1.01
1.02	00102	OPS		148,219		148,219	1.02
4.00	00400	EMPLOYEE BENEFITS	234,577	7,163,678		7,398,255	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,610,291	5,070,904	450,318	8,131,513	5.00
7.00	00700	OPERATION OF PLANT	469,891	1,880,139		2,350,030	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	182,711		182,711	8.00
9.00	00900	HOUSEKEEPING	497,854	218,133		715,987	9.00
10.00	01000	DIETARY	645,994	388,934		1,034,928	10.00
11.00	01100	CAFETERIA	0	0		685,265	11.00
13.00	01300	NURSING ADMINISTRATION	449,992	12,659		462,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	162,852	1,977,023		2,139,875	14.00
15.00	01500	PHARMACY	395,925	1,045,095		1,441,020	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	522,272	83,803		606,075	16.00
17.00	01700	SOCIAL SERVICE	278,224	37,264		315,488	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,089,214	348,617		3,437,831	30.00
31.00	03100	INTENSIVE CARE UNIT	561,342	39,032		600,374	31.00
41.00	04100	SUBPROVIDER - I RF	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0		0	42.00
43.00	04300	NURSERY	736	412	1,148	297,289	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,354,737	721,558		2,076,295	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,003	7,383		73,386	52.00
53.00	05300	ANESTHESIOLOGY	0	21,918		21,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,019,839	882,174		1,902,013	54.00
57.00	05700	CT SCAN	0	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	59.00
60.00	06000	LABORATORY	1,043,213	1,516,236		2,559,449	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	45,508	218,574		264,082	63.00
65.00	06500	RESPIRATORY THERAPY	529,570	65,813		595,383	65.00
66.00	06600	PHYSICAL THERAPY	43,197	478,582		521,779	66.00
69.00	06900	ELECTROCARDIOLOGY	221,396	43,061		264,457	69.00
69.01	06901	CARDIAC REHAB	89,485	5,257		94,742	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		574,230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	185,950	333,606		519,556	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,265,985	491,793		3,757,778	90.00
91.00	09100	EMERGENCY	1,555,232	232,304		1,787,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	93.00
93.01	04041	FAMILY PRACTICE	0	0		0	93.01
93.02	04042	FAMILY PRACTICE	0	0		0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	171,487	39,000		210,487	95.00
99.10	09910	CORF	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,510,766	27,557,445		47,068,211	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	12,809		12,809	194.00
194.01	07951	MOB	2,950	8,043		10,993	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0		0	194.02
194.03	07953	PIH	0	0		0	194.03
194.04	07954	HEALTH COMPANIES	633,089	245,041		878,130	194.04
194.05	07955	PHYSICIANS OFFICE	6,402,884	2,442,973		8,845,857	194.05
194.06	07956	THE ARBORS	0	19		19	194.06
194.08	07958	OPS	0	0		0	194.08
200.00		TOTAL (SUM OF LINES 118-199)	26,549,689	30,266,330		56,816,019	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150072

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

Worksheet A
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-12,915	3,391,457	1.00
1.01	00101 MOB	0	252,874	1.01
1.02	00102 OPS	0	148,219	1.02
4.00	00400 EMPLOYEE BENEFITS	-2,338	7,395,917	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-2,969,827	5,161,686	5.00
7.00	00700 OPERATION OF PLANT	-15,715	2,334,315	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	14,633	197,344	8.00
9.00	00900 HOUSEKEEPING	0	715,987	9.00
10.00	01000 DIETARY	-44,210	305,453	10.00
11.00	01100 CAFETERIA	-278,084	407,181	11.00
13.00	01300 NURSING ADMINISTRATION	-6,991	455,660	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,565,645	14.00
15.00	01500 PHARMACY	0	1,441,020	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-23,364	582,711	16.00
17.00	01700 SOCIAL SERVICE	-37	315,451	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-28	2,654,370	30.00
31.00	03100 INTENSIVE CARE UNIT	0	600,374	31.00
41.00	04100 SUBPROVIDER - IIRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	298,437	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	2,076,295	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-1,146	558,384	52.00
53.00	05300 ANESTHESIOLOGY	0	21,918	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,902,013	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	-22	2,559,427	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	264,082	63.00
65.00	06500 RESPIRATORY THERAPY	-29,684	565,699	65.00
66.00	06600 PHYSICAL THERAPY	0	521,779	66.00
69.00	06900 ELECTROCARDIOLOGY	0	264,457	69.00
69.01	06901 CARDIAC REHAB	-2,702	92,040	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	574,230	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	519,556	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-1,934,158	1,823,620	90.00
91.00	09100 EMERGENCY	-126,022	1,661,514	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	93.02
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	210,487	95.00
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5,432,610	41,839,602	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950 FOUNDATION	0	12,809	194.00
194.01	07951 MOB	0	10,993	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.03	07953 PIH	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	878,130	194.04
194.05	07955 PHYSICIANS OFFICE	0	8,641,856	194.05
194.06	07956 THE ARBORS	0	19	194.06
194.08	07958 OPS	0	0	194.08
200.00	TOTAL (SUM OF LINES 118-199)	-5,432,610	51,383,409	200.00

Provider CCN: 150072

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

Worksheet A-6
Date/Time Prepared:
5/29/2013 6:41 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	427,737	257,528	1.00
	TOTALS		427,737	257,528	
B - OBSTETRICS					
1.00	NURSERY	43.00	247,078	50,211	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	398,616	87,528	2.00
	TOTALS		645,694	137,739	
C - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	450,318	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	450,318	
D - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	574,230	1.00
	TOTALS		0	574,230	
500.00	Grand Total: Increases		1,073,431	1,419,815	500.00

RECLASSIFICATIONS

Provider CCN: 150072

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

Worksheet A-6

Date/Time Prepared:
5/29/2013 6:41 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	427,737	257,528	0		1.00
	TOTALS		427,737	257,528			
B - OBSTETRICS							
1.00	ADULTS & PEDIATRICS	30.00	645,694	137,739	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		645,694	137,739			
C - MALPRACTICE INSURANCE							
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	246,317	12		1.00
2.00	PHYSICIANS OFFICE	194.05	0	204,001	0		2.00
	TOTALS		0	450,318			
D - IMPLANTABLE DEVICES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	574,230	0		1.00
	TOTALS		0	574,230			
500.00	Grand Total: Decreases		1,073,431	1,419,815			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150072

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2013 6:41 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	137,562	68,221	0	68,221	0	1.00
2.00	Land Improvements	443,093	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,756,397	638,239	0	638,239	100,053	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	29,359,300	1,511,163	0	1,511,163	46,984	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	86,696,352	2,217,623	0	2,217,623	147,037	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	86,696,352	2,217,623	0	2,217,623	147,037	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	205,783	0				1.00
2.00	Land Improvements	443,093	0				2.00
3.00	Buildings and Fixtures	57,294,583	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	30,823,479	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)	88,766,938	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	88,766,938	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150072

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,138,553	0	142,526	369,610	0	1.00
1.01	MOB	252,874	0	0	0	0	1.01
1.02	OPS	148,219	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	3,539,646	0	142,526	369,610	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,650,689				1.00
1.01	MOB	0	252,874				1.01
1.02	OPS	0	148,219				1.02
3.00	Total (sum of lines 1-2)	0	4,051,782				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150072

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	OPS	0	0	0	0.000000	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,125,638	0	1.00
1.01	MOB	0	0	0	252,874	0	1.01
1.02	OPS	0	0	0	148,219	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	3,526,731	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	142,526	123,293	0	0	3,391,457	1.00
1.01	MOB	0	0	0	0	252,874	1.01
1.02	OPS	0	0	0	0	148,219	1.02
3.00	Total (sum of lines 1-2)	142,526	123,293	0	0	3,792,550	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150072

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

Worksheet A-8

Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst.	A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
1.01 Investment income - MOB (chapter 2)			0MOB	1.01		0 1.01
1.02 Investment income - OPS (chapter 2)			0OPS	1.02		0 1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	2.00		0 2.00
3.00 Investment income - other (chapter 2)			0	0.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0	0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)			0	0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)			0	0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0	0.00		0 7.00
8.00 Television and radio service (chapter 21)			0	0.00		0 8.00
9.00 Parking lot (chapter 21)			0	0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,097,799				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0	0.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	33,925				0 12.00
13.00 Laundry and linen service			0	0.00		0 13.00
14.00 Cafeteria-employees and guests	A	-278,084	CAFETERIA	11.00		0 14.00
15.00 Rental of quarters to employee and others			0	0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients			0	0.00		0 16.00
17.00 Sale of drugs to other than patients			0	0.00		0 17.00
18.00 Sale of medical records and abstracts			0	0.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0	0.00		0 19.00
20.00 Vending machines			0	0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
26.01 Depreciation - MOB			0MOB	1.01		0 26.01
26.02 Depreciation - OPS			0OPS	1.02		0 26.02
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0*** Cost Center Deleted ***	2.00		0 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00		0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00

31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			31.00		
				Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.
						*** Cost Center Deleted ***	68.00		
32.00	CAH HIT Adjustment for Depreciation and Interest		0				0.00	0	32.00
33.00	OTHER REVENUE - VENDING COMMISSION	B	-10,052			ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE - CASH OVER/SHORT	B	-22			ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER REVENUE - MISCELLANEOUS	B	-37,980			ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER REVENUE - BAD DEBT	B	-576			ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER REVENUE - MEDICAL CARE	B	23			ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER REVENUE - BLUE CROSS	B	-129			ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHER REVENUE - MEDICAL	B	-67			ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	OTHER REVENUE - SCRAP SAL	B	-3,838			ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER REVENUE - CASH OVER	B	-48			ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	OTHER REVENUE - REBATES (B	-22,958			ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	OTHER REVENUE - VEHICLE	B	-3,600			ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	MHL A/P DISCOUNTS	B	-562			ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	OTHER REVENUE - REBATES	B	-240			ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MHL TELEPHONE-PAY PHONES	B	-51			ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MHL TELEPHONE SERVICE	B	-11,674			ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	OTHER REVENUE - NUTRITIONALS	B	-1,318			DIETARY	10.00	0	45.03
45.04	OTHER REVENUE - REBATES	B	-1,063			DIETARY	10.00	0	45.04
45.05	MEALS ON WHEELS	B	-41,829			DIETARY	10.00	0	45.05
45.06	OTHER REVENUE - CPR TRAINING	B	-48			NURSING ADMINISTRATION	13.00	0	45.06
45.07	OTHER REVENUE - ACLS REVENUE	B	-155			NURSING ADMINISTRATION	13.00	0	45.07
45.08	OTHER REVENUE - MISCELLANEOUS	B	-6,788			NURSING ADMINISTRATION	13.00	0	45.08
45.09	HIM MEDICAL RECORDS FEES	B	-23,364			MEDICAL RECORDS & LIBRARY	16.00	0	45.09
45.10	PATIENT TELEVISIONS	A	-1,026			OPERATION OF PLANT	7.00	0	45.10
45.11	PATIENT TELEVISIONS	A	-1,759			NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.11
45.12	PATIENT TELEPHONES	A	-2,338			EMPLOYEE BENEFITS	4.00	0	45.12
45.13	PATIENT TELEPHONES	A	-3,334			NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.14	PATIENT TELEPHONES	A	-1,538			ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	IHA & AHA LOBBYING FEES	A	-6,372			ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	GIFT SHOP	A	-17,804			NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.16
45.17	GIFT SHOP	A	-12,440			OPERATION OF PLANT	7.00	0	45.17
45.18	ADVERTISING	A	-359,853			ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	TAXES	A	-51,870			ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	DONATION EXPENSE	A	-24,010			ADMINISTRATIVE & GENERAL	5.00	0	45.20
45.21	PHYSICIAN RECRUITMENT	A	-209,558			ADMINISTRATIVE & GENERAL	5.00	0	45.21
45.22	CAPITALIZED INTEREST	A	-6,091			NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.22
45.23	VENDING	A	-2,249			OPERATION OF PLANT	7.00	0	45.23
45.24	VENDING	A	-3,219			NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.24
45.25	HOSPITAL ASSESSMENT FEES	A	-2,220,852			ADMINISTRATIVE & GENERAL	5.00	0	45.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,432,610						50.00

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

Provider CCN: 150072

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2013 6:41 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	19,292	0	1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	197,344	182,711	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0		216,636	182,711	5.00

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

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

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

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

6.00	C	NCI LINEN SERVI	33.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 150072

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2013 6:41 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	19,292	9		1.00
2.00	14,633	0		2.00
3.00	0	9		3.00
4.00	0	0		4.00
5.00	33,925			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150072

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2013 6:41 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,000	4,000	0	159,800	0	1.00
2.00	17.00	SOCIAL SERVICE	30,000	0	30,000	159,800	390	2.00
3.00	30.00	ADULTS & PEDIATRICS	4,650	0	4,650	200,300	48	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	5,602	0	5,602	159,800	58	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	50,004	0	50,004	217,600	478	5.00
6.00	60.00	LABORATORY	62,822	0	62,822	208,000	628	6.00
7.00	65.00	RESPIRATORY THERAPY	29,684	29,684	0	159,800	0	7.00
8.00	69.01	CARDIAC REHAB	13,005	2,702	10,303	159,800	134	8.00
9.00	90.00	CLINIC	2,013,755	1,931,423	82,332	142,500	881	9.00
10.00	91.00	EMERGENCY	126,022	126,022	0	159,800	0	10.00
200.00			2,339,544	2,093,831	245,713		2,617	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	29,963	1,498	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	4,622	231	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	4,456	223	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	50,006	2,500	0	0	0	5.00
6.00	60.00	LABORATORY	62,800	3,140	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	3,674	7.00
8.00	69.01	CARDIAC REHAB	10,295	515	0	0	2,702	8.00
9.00	90.00	CLINIC	60,357	3,018	0	0	470,583	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			222,499	11,125	0	0	476,959	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	4,000		1.00
2.00	17.00	SOCIAL SERVICE	0	29,963	37	37		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	4,622	28	28		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	4,456	1,146	1,146		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	50,006	0	0		5.00
6.00	60.00	LABORATORY	0	62,800	22	22		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	29,684		7.00
8.00	69.01	CARDIAC REHAB	2,141	12,436	0	2,702		8.00
9.00	90.00	CLINIC	19,240	79,597	2,735	1,934,158		9.00
10.00	91.00	EMERGENCY	0	0	0	126,022		10.00
200.00			21,381	243,880	3,968	2,097,799		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	MOB	OPS		
	0	1.00	1.01	1.02	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	3,391,457	3,391,457			1.00
1.01 00101	MOB	252,874	0	252,874		1.01
1.02 00102	OPS	148,219	0	0	148,219	1.02
4.00 00400	EMPLOYEE BENEFITS	7,395,917	25,884	0	0	7,421,801
5.00 00500	ADMINISTRATIVE & GENERAL	5,161,686	118,540	24,967	3,583	736,196
7.00 00700	OPERATION OF PLANT	2,334,315	658,922	0	0	132,526
8.00 00800	LAUNDRY & LINEN SERVICE	197,344	11,355	0	0	0
9.00 00900	HOUSEKEEPING	715,987	34,874	0	0	140,413
10.00 01000	DIETARY	305,453	121,359	0	0	61,556
11.00 01100	CAFETERIA	407,181	88,398	0	0	120,637
13.00 01300	NURSING ADMINISTRATION	455,660	66,456	0	0	126,914
14.00 01400	CENTRAL SERVICES & SUPPLY	1,565,645	125,716	0	0	45,930
15.00 01500	PHARMACY	1,441,020	38,186	0	0	111,665
16.00 01600	MEDICAL RECORDS & LIBRARY	582,711	28,960	0	0	147,300
17.00 01700	SOCIAL SERVICE	315,451	9,305	0	0	78,469
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,654,370	592,918	0	0	689,161
31.00 03100	INTENSIVE CARE UNIT	600,374	81,438	0	0	158,319
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	298,437	7,807	0	0	69,892
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,076,295	281,299	0	0	382,085
52.00 05200	DELIVERY ROOM & LABOR ROOM	558,384	69,728	0	0	131,039
53.00 05300	ANESTHESIOLOGY	21,918	32,922	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,902,013	202,285	0	10,192	287,631
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	2,559,427	76,234	0	4,931	294,224
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	264,082	0	0	0	12,835
65.00 06500	RESPIRATORY THERAPY	565,699	60,621	0	0	149,358
66.00 06600	PHYSICAL THERAPY	521,779	47,668	0	0	12,183
69.00 06900	ELECTROCARDIOLOGY	264,457	0	14,823	0	62,442
69.01 06901	CARDIAC REHAB	92,040	20,108	0	0	25,238
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	574,230	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	NUCLEAR MEDICINE-DIAGNOSTIC	519,556	47,511	15,254	0	52,445
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,823,620	1,183	67,716	0	921,125
91.00 09100	EMERGENCY	1,661,514	213,365	0	0	438,631
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01 04041	FAMILY PRACTICE	0	0	0	0	0
93.02 04042	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	210,487	52,695	0	0	48,366
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,839,602	3,115,737	122,760	18,706	5,436,580
NONREIMBURSABLE COST CENTERS						
194.00 07950	FOUNDATION	12,809	1,419	0	0	0
194.01 07951	MOB	10,993	0	130,114	0	832
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03 07953	PIH	0	0	0	0	0
194.04 07954	HEALTH COMPANIES	878,130	0	0	0	178,554
194.05 07955	PHYSICIANS OFFICE	8,641,856	88,713	0	0	1,805,835
194.06 07956	THE ARBORS	19	185,588	0	0	0
194.08 07958	OPS	0	0	0	129,513	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	51,383,409	3,391,457	252,874	148,219	7,421,801

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B
Part I
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,044,972	6,044,972			5.00
7.00	00700	OPERATION OF PLANT	3,125,763	416,758	3,542,521		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	208,699	27,826	10,644	247,169	8.00
9.00	00900	HOUSEKEEPING	891,274	118,834	32,690	0	1,042,798
10.00	01000	DIETARY	488,368	65,114	113,759	3,599	13,721
11.00	01100	CAFETERIA	616,216	82,160	82,862	7,053	10,013
13.00	01300	NURSING ADMINISTRATION	649,030	86,535	62,294	0	3,708
14.00	01400	CENTRAL SERVICES & SUPPLY	1,737,291	231,633	117,843	196	8,900
15.00	01500	PHARMACY	1,590,871	212,111	35,795	0	3,708
16.00	01600	MEDICAL RECORDS & LIBRARY	758,971	101,194	27,146	0	4,450
17.00	01700	SOCIAL SERVICE	403,225	53,762	8,722	0	1,483
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,936,449	524,847	555,786	73,595	349,700
31.00	03100	INTENSIVE CARE UNIT	840,131	112,015	76,338	11,584	59,334
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	376,136	50,150	7,318	5,185	2,967
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,739,679	365,281	340,557	39,817	59,334
52.00	05200	DELIVERY ROOM & LABOR ROOM	759,151	101,218	65,362	0	27,071
53.00	05300	ANESTHESIOLOGY	54,840	7,312	30,861	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,402,121	320,275	219,794	17,333	75,095
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,934,816	391,299	86,059	570	22,436
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	276,917	36,921	0	0	0
65.00	06500	RESPIRATORY THERAPY	775,678	103,421	56,824	2,561	11,125
66.00	06600	PHYSICAL THERAPY	581,630	77,549	44,683	8,031	17,059
69.00	06900	ELECTROCARDIOLOGY	341,722	45,562	69,021	92	7,417
69.01	06901	CARDIAC REHAB	137,386	18,318	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	574,230	76,562	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	634,766	84,633	96,167	4,750	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,813,644	375,143	263,738	0	28,184
91.00	09100	EMERGENCY	2,313,510	308,460	200,003	41,948	96,418
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01	04041	FAMILY PRACTICE	0	0	0	0	0
93.02	04042	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	311,548	41,539	49,395	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,319,034	4,436,432	2,653,661	216,314	802,123
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	14,228	1,897	1,331	0	11,867
194.01	07951	MOB	141,939	18,925	330,098	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	1,056,684	140,888	0	0	14,834
194.05	07955	PHYSICIANS OFFICE	10,536,404	1,404,815	0	1,072	0
194.06	07956	THE ARBORS	185,607	24,747	173,965	29,783	41,534
194.08	07958	OPS	129,513	17,268	383,466	0	172,440
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	51,383,409	6,044,972	3,542,521	247,169	1,042,798

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B
Part I
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 OPS						1.02
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	684,561					10.00
11.00	01100 CAFETERIA	0	798,304				11.00
13.00	01300 NURSING ADMINISTRATION	0	11,775	813,342			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	12,067	0	2,107,930		14.00
15.00	01500 PHARMACY	0	24,396	0	0	1,866,881	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	34,264	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	11,120	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	348,305	114,915	313,462	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	39,588	27,349	74,602	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	9,634	26,279	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	58,624	159,911	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	18,062	49,268	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	45,294	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	63,144	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2,321	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	25,002	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,724	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	11,466	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	5,160	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,107,930	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	1,866,881	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	6,814	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	109,305	0	0	0	90.00
91.00	09100 EMERGENCY	0	69,588	189,820	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	11,647	0	0	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	387,893	674,671	813,342	2,107,930	1,866,881	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950 FOUNDATION	0	0	0	0	0	194.00
194.01	07951 MOB	0	345	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 PIH	0	0	0	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	28,010	0	0	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	95,278	0	0	0	194.05
194.06	07956 THE ARBORS	296,668	0	0	0	0	194.06
194.08	07958 OPS	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	684,561	798,304	813,342	2,107,930	1,866,881	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150072

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

Worksheet B
Part I
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
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	926,025				16.00
17.00	01700	SOCIAL SERVICE	0	478,312			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	180,586	448,055	6,845,700	0	6,845,700
31.00	03100	INTENSIVE CARE UNIT	23,460	17,979	1,282,380	0	1,282,380
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	477,669	0	477,669
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	488,129	0	4,251,332	0	4,251,332
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,020,132	0	1,020,132
53.00	05300	ANESTHESIOLOGY	0	0	93,013	0	93,013
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,079,912	0	3,079,912
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	3,498,324	0	3,498,324
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	316,159	0	316,159
65.00	06500	RESPIRATORY THERAPY	0	0	974,611	0	974,611
66.00	06600	PHYSICAL THERAPY	0	0	731,676	0	731,676
69.00	06900	ELECTROCARDIOLOGY	0	0	475,280	0	475,280
69.01	06901	CARDIAC REHAB	0	0	160,864	0	160,864
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,107,930	0	2,107,930
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	650,792	0	650,792
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,866,881	0	1,866,881
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	827,130	0	827,130
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	3,590,014	0	3,590,014
91.00	09100	EMERGENCY	217,568	12,278	3,449,593	0	3,449,593
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	16,282	0	430,411	0	430,411
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	926,025	478,312	36,129,803	0	36,129,803
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	29,323	0	29,323
194.01	07951	MOB	0	0	491,307	0	491,307
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	1,240,416	0	1,240,416
194.05	07955	PHYSICIANS OFFICE	0	0	12,037,569	0	12,037,569
194.06	07956	THE ARBORS	0	0	752,304	0	752,304
194.08	07958	OPS	0	0	702,687	0	702,687
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	926,025	478,312	51,383,409	0	51,383,409

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	MOB	OPS		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	MOB					1.01
1.02 00102	OPS					1.02
4.00 00400	EMPLOYEE BENEFITS	0	25,884	0	0	25,884 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	118,540	24,967	3,583	147,090 5.00
7.00 00700	OPERATION OF PLANT	0	658,922	0	0	658,922 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,355	0	0	11,355 8.00
9.00 00900	HOUSEKEEPING	0	34,874	0	0	34,874 9.00
10.00 01000	DIETARY	0	121,359	0	0	121,359 10.00
11.00 01100	CAFETERIA	0	88,398	0	0	88,398 11.00
13.00 01300	NURSING ADMINISTRATION	0	66,456	0	0	66,456 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	125,716	0	0	125,716 14.00
15.00 01500	PHARMACY	0	38,186	0	0	38,186 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	28,960	0	0	28,960 16.00
17.00 01700	SOCIAL SERVICE	0	9,305	0	0	9,305 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	592,918	0	0	592,918 30.00
31.00 03100	INTENSIVE CARE UNIT	0	81,438	0	0	81,438 31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	7,807	0	0	7,807 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	281,299	0	0	281,299 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	69,728	0	0	69,728 52.00
53.00 05300	ANESTHESIOLOGY	0	32,922	0	0	32,922 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	202,285	0	10,192	212,477 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	76,234	0	4,931	81,165 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	0	60,621	0	0	60,621 65.00
66.00 06600	PHYSICAL THERAPY	0	47,668	0	0	47,668 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	14,823	0	14,823 69.00
69.01 06901	CARDIAC REHAB	0	20,108	0	0	20,108 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
76.00 03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	47,511	15,254	0	62,765 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	1,183	67,716	0	68,899 90.00
91.00 09100	EMERGENCY	0	213,365	0	0	213,365 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
93.01 04041	FAMILY PRACTICE	0	0	0	0	0 93.01
93.02 04042	FAMILY PRACTICE	0	0	0	0	0 93.02
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	52,695	0	0	52,695 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,115,737	122,760	18,706	3,257,203 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	FOUNDATION	0	1,419	0	0	1,419 194.00
194.01 07951	MOB	0	0	130,114	0	130,114 194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
194.03 07953	PIH	0	0	0	0	0 194.03
194.04 07954	HEALTH COMPANIES	0	0	0	0	0 194.04
194.05 07955	PHYSICIANS OFFICE	0	88,713	0	0	88,713 194.05
194.06 07956	THE ARBORS	0	185,588	0	0	185,588 194.06
194.08 07958	OPS	0	0	0	129,513	129,513 194.08
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	0	3,391,457	252,874	148,219	3,792,550 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
4.00	00400	25,884					4.00
5.00	00500	2,569	149,659				5.00
7.00	00700	462	10,318	669,702			7.00
8.00	00800	0	689	2,012	14,056		8.00
9.00	00900	490	2,942	6,180	0	44,486	9.00
10.00	01000	215	1,612	21,506	205	585	10.00
11.00	01100	421	2,034	15,665	401	427	11.00
13.00	01300	443	2,142	11,776	0	158	13.00
14.00	01400	160	5,735	22,278	11	380	14.00
15.00	01500	390	5,251	6,767	0	158	15.00
16.00	01600	514	2,505	5,132	0	190	16.00
17.00	01700	274	1,331	1,649	0	63	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,404	12,994	105,070	4,185	14,919	30.00
31.00	03100	552	2,773	14,432	659	2,531	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	244	1,242	1,383	295	127	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,333	9,044	64,381	2,264	2,531	50.00
52.00	05200	457	2,506	12,356	0	1,155	52.00
53.00	05300	0	181	5,834	0	0	53.00
54.00	05400	1,004	7,929	41,551	986	3,204	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,027	9,688	16,269	32	957	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	45	914	0	0	0	63.00
65.00	06500	521	2,561	10,742	146	475	65.00
66.00	06600	43	1,920	8,447	457	728	66.00
69.00	06900	218	1,128	13,048	5	316	69.00
69.01	06901	88	454	0	0	0	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	1,896	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	183	2,095	18,180	270	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,214	9,288	49,859	0	1,202	90.00
91.00	09100	1,530	7,637	37,810	2,385	4,113	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
93.01	04041	0	0	0	0	0	93.01
93.02	04042	0	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	169	1,028	9,338	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		18,970	109,837	501,665	12,301	34,219	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	47	252	0	506	194.00
194.01	07951	3	469	62,404	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	623	3,488	0	0	633	194.04
194.05	07955	6,288	34,777	0	61	0	194.05
194.06	07956	0	613	32,888	1,694	1,772	194.06
194.08	07958	0	428	72,493	0	7,356	194.08
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		25,884	149,659	669,702	14,056	44,486	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 OPS						1.02
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	145,482					10.00
11.00	01100 CAFETERIA	0	107,346				11.00
13.00	01300 NURSING ADMINISTRATION	0	1,583	82,558			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,623	0	155,903		14.00
15.00	01500 PHARMACY	0	3,281	0	0	54,033	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4,607	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	1,495	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	74,022	15,453	31,818	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	8,413	3,678	7,572	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	1,295	2,667	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	7,883	16,232	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,429	5,001	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,091	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	8,491	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	312	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	3,362	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	366	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,542	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	694	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	155,903	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	54,033	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	916	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	14,698	0	0	0	90.00
91.00	09100 EMERGENCY	0	9,357	19,268	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	1,566	0	0	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	82,435	90,722	82,558	155,903	54,033	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950 FOUNDATION	0	0	0	0	0	194.00
194.01	07951 MOB	0	46	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 PIH	0	0	0	0	0	194.03
194.04	07954 HEALTH COMPANIES	0	3,766	0	0	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	12,812	0	0	0	194.05
194.06	07956 THE ARBORS	63,047	0	0	0	0	194.06
194.08	07958 OPS	0	0	0	0	0	194.08
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)	145,482	107,346	82,558	155,903	54,033	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150072

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
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	41,908				16.00
17.00	01700	SOCIAL SERVICE	0	14,117			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,169	13,224	875,176	0	875,176
31.00	03100	INTENSIVE CARE UNIT	1,061	531	123,640	0	123,640
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	15,060	0	15,060
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,099	0	407,066	0	407,066
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	93,632	0	93,632
53.00	05300	ANESTHESIOLOGY	0	0	38,937	0	38,937
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	273,242	0	273,242
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	117,629	0	117,629
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,271	0	1,271
65.00	06500	RESPIRATORY THERAPY	0	0	78,428	0	78,428
66.00	06600	PHYSICAL THERAPY	0	0	59,629	0	59,629
69.00	06900	ELECTROCARDIOLOGY	0	0	31,080	0	31,080
69.01	06901	CARDIAC REHAB	0	0	21,344	0	21,344
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	155,903	0	155,903
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,896	0	1,896
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,033	0	54,033
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	84,409	0	84,409
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	147,160	0	147,160
91.00	09100	EMERGENCY	9,842	362	305,669	0	305,669
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	737	0	65,533	0	65,533
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,908	14,117	2,950,737	0	2,950,737
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	0	0	2,224	0	2,224
194.01	07951	MOB	0	0	193,036	0	193,036
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	8,510	0	8,510
194.05	07955	PHYSICIANS OFFICE	0	0	142,651	0	142,651
194.06	07956	THE ARBORS	0	0	285,602	0	285,602
194.08	07958	OPS	0	0	209,790	0	209,790
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,908	14,117	3,792,550	0	3,792,550

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
		1.00	1.01	1.02			
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	172,033				1.00
1.01	00101	MOB	0	46,317			1.01
1.02	00102	OPS	0	0	23,748		1.02
4.00	00400	EMPLOYEE BENEFITS	1,313	0	0	26,315,112	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,013	4,573	574	2,610,291	-6,044,972
7.00	00700	OPERATION OF PLANT	33,424	0	0	469,891	0
8.00	00800	LAUNDRY & LINEN SERVICE	576	0	0	0	0
9.00	00900	HOUSEKEEPING	1,769	0	0	497,854	0
10.00	01000	DIETARY	6,156	0	0	218,257	0
11.00	01100	CAFETERIA	4,484	0	0	427,737	0
13.00	01300	NURSING ADMINISTRATION	3,371	0	0	449,992	0
14.00	01400	CENTRAL SERVICES & SUPPLY	6,377	0	0	162,852	0
15.00	01500	PHARMACY	1,937	0	0	395,925	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,469	0	0	522,272	0
17.00	01700	SOCIAL SERVICE	472	0	0	278,224	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,076	0	0	2,443,520	0
31.00	03100	INTENSIVE CARE UNIT	4,131	0	0	561,342	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	396	0	0	247,814	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,269	0	0	1,354,737	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,537	0	0	464,619	0
53.00	05300	ANESTHESIOLOGY	1,670	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,261	0	1,633	1,019,839	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,867	0	790	1,043,213	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	45,508	0
65.00	06500	RESPIRATORY THERAPY	3,075	0	0	529,570	0
66.00	06600	PHYSICAL THERAPY	2,418	0	0	43,197	0
69.00	06900	ELECTROCARDIOLOGY	0	2,715	0	221,396	0
69.01	06901	CARDIAC REHAB	1,020	0	0	89,485	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	2,410	2,794	0	185,950	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	60	12,403	0	3,265,985	0
91.00	09100	EMERGENCY	10,823	0	0	1,555,232	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01	04041	FAMILY PRACTICE	0	0	0	0	0
93.02	04042	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,673	0	0	171,487	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	158,047	22,485	2,997	19,276,189	-6,044,972
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	72	0	0	0	0
194.01	07951	MOB	0	23,832	0	2,950	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	0	0	0	633,089	0
194.05	07955	PHYSICIANS OFFICE	4,500	0	0	6,402,884	0
194.06	07956	THE ARBORS	9,414	0	0	0	0
194.08	07958	OPS	0	0	20,751	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	3,391,457	252,874	148,219	7,421,801	
203.00		Unit cost multiplier (Wkst. B, Part I)	19.713991	5.459637	6.241326	0.282036	
204.00		Cost to be allocated (per Wkst. B, Part II)				25,884	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)			
	1.00	1.01	1.02			
205.00 Unit cost multiplier (Wkst. B, Part 11)				4.00 0.000984	5A	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	OPS					1.02
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,338,437				5.00
7.00	00700	OPERATION OF PLANT	3,125,763	191,701			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	208,699	576	350,621		8.00
9.00	00900	HOUSEKEEPING	891,274	1,769	0	5,624	9.00
10.00	01000	DIETARY	488,368	6,156	5,106	74	11,136
11.00	01100	CAFETERIA	616,216	4,484	10,005	54	0
13.00	01300	NURSING ADMINISTRATION	649,030	3,371	0	20	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,737,291	6,377	278	48	0
15.00	01500	PHARMACY	1,590,871	1,937	0	20	0
16.00	01600	MEDICAL RECORDS & LIBRARY	758,971	1,469	0	24	0
17.00	01700	SOCIAL SERVICE	403,225	472	0	8	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,936,449	30,076	104,398	1,886	5,666
31.00	03100	INTENSIVE CARE UNIT	840,131	4,131	16,433	320	644
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	376,136	396	7,355	16	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,739,679	18,429	56,482	320	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	759,151	3,537	0	146	0
53.00	05300	ANESTHESIOLOGY	54,840	1,670	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,402,121	11,894	24,587	405	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,934,816	4,657	808	121	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	276,917	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	775,678	3,075	3,633	60	0
66.00	06600	PHYSICAL THERAPY	581,630	2,418	11,393	92	0
69.00	06900	ELECTROCARDIOLOGY	341,722	3,735	130	40	0
69.01	06901	CARDIAC REHAB	137,386	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	574,230	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	634,766	5,204	6,738	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,813,644	14,272	0	152	0
91.00	09100	EMERGENCY	2,313,510	10,823	59,505	520	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.01	04041	FAMILY PRACTICE	0	0	0	0	0
93.02	04042	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	311,548	2,673	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,274,062	143,601	306,851	4,326	6,310
NONREIMBURSABLE COST CENTERS							
194.00	07950	FOUNDATION	14,228	72	0	64	0
194.01	07951	MOB	141,939	17,863	0	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	PIH	0	0	0	0	0
194.04	07954	HEALTH COMPANIES	1,056,684	0	0	80	0
194.05	07955	PHYSICIANS OFFICE	10,536,404	0	1,521	0	0
194.06	07956	THE ARBORS	185,607	9,414	42,249	224	4,826
194.08	07958	OPS	129,513	20,751	0	930	0
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)	6,044,972	3,542,521	247,169	1,042,798	684,561
203.00		Unit cost multiplier (Wkst. B, Part I)	0.133330	18.479408	0.704946	185.419275	61.472791
204.00		Cost to be allocated (per Wkst. B, Part II)	149,659	669,702	14,056	44,486	145,482
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003301	3.493472	0.040089	7.910028	13.064116

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
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	721,234					11.00
13.00	01300	10,638	269,386				13.00
14.00	01400	10,902	0	100			14.00
15.00	01500	22,041	0	0	100		15.00
16.00	01600	30,956	0	0	0	45,731,969	16.00
17.00	01700	10,046	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	103,821	103,821	0	0	8,918,244	30.00
31.00	03100	24,709	24,709	0	0	1,158,599	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	8,704	8,704	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	52,964	52,964	0	0	24,106,427	50.00
52.00	05200	16,318	16,318	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	40,921	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	57,048	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	2,097	0	0	0	0	63.00
65.00	06500	22,588	0	0	0	0	65.00
66.00	06600	2,461	0	0	0	0	66.00
69.00	06900	10,359	0	0	0	0	69.00
69.01	06901	4,662	0	0	0	0	69.01
71.00	07100	0	0	100	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	100	0	73.00
76.00	03020	6,156	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	98,752	0	0	0	0	90.00
91.00	09100	62,870	62,870	0	0	10,744,625	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
93.01	04041	0	0	0	0	0	93.01
93.02	04042	0	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	10,523	0	0	0	804,074	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00		609,536	269,386	100	100	45,731,969	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	312	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	25,306	0	0	0	0	194.04
194.05	07955	86,080	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	0	0	0	0	0	194.08
200.00							200.00
201.00							201.00
202.00		798,304	813,342	2,107,930	1,866,881	926,025	202.00
203.00		1.106859	3.019244	21,079.300000	18,668.810000	0.020249	203.00
204.00		107,346	82,558	155,903	54,033	41,908	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
205.00	Unit cost multiplier (Wkst. B, Part II)	11.00 0.148837	13.00 0.306467	14.00 1,559.030000	15.00 540.330000	16.00 0.000916	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150072

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

Worksheet B-1
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Cost Center Description		SOCIAL SERVICE	
		(HOURS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101 MOB		1.01
1.02	00102 OPS		1.02
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	21,815	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	20,435	30.00
31.00	03100 INTENSIVE CARE UNIT	820	31.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	0	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	65.00
66.00	06600 PHYSICAL THERAPY	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
69.01	06901 CARDIAC REHAB	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	560	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
93.01	04041 FAMILY PRACTICE	0	93.01
93.02	04042 FAMILY PRACTICE	0	93.02
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0	95.00
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,815	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 FOUNDATION	0	194.00
194.01	07951 MOB	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.03	07953 PIH	0	194.03
194.04	07954 HEALTH COMPANIES	0	194.04
194.05	07955 PHYSICIANS OFFICE	0	194.05
194.06	07956 THE ARBORS	0	194.06
194.08	07958 OPS	0	194.08
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)	478,312	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.925831	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	14,117	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.647124	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	6,845,700		6,845,700	28	6,845,728	8,918,244	30.00
31.00	03100	INTENSIVE CARE UNIT	1,282,380		1,282,380	0	1,282,380	1,069,073	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	477,669		477,669	0	477,669	1,266,348	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,251,332		4,251,332	0	4,251,332	5,060,489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,020,132		1,020,132	1,146	1,021,278	1,726,490	52.00
53.00	05300	ANESTHESIOLOGY	93,013		93,013	0	93,013	297,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,079,912		3,079,912	0	3,079,912	992,355	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	3,498,324		3,498,324	22	3,498,346	3,317,624	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	316,159		316,159	0	316,159	469,806	63.00
65.00	06500	RESPIRATORY THERAPY	974,611	0	974,611	0	974,611	2,399,898	65.00
66.00	06600	PHYSICAL THERAPY	731,676	0	731,676	0	731,676	429,269	66.00
69.00	06900	ELECTROCARDIOLOGY	475,280		475,280	0	475,280	623,456	69.00
69.01	06901	CARDIAC REHAB	160,864		160,864	0	160,864	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,107,930		2,107,930	0	2,107,930	2,018,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	650,792		650,792	0	650,792	1,964,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,881		1,866,881	0	1,866,881	4,422,144	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	827,130		827,130	0	827,130	1,728,845	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,590,014		3,590,014	2,735	3,592,749	13,239	90.00
91.00	09100	EMERGENCY	3,449,593		3,449,593	0	3,449,593	1,333,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,407,924		1,407,924		1,407,924	112,771	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0		0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0		0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	430,411		430,411	0	430,411	181,450	95.00
99.10	09910	CORF	0		0	0	0	0	99.10
200.00		Subtotal (see instructions)	37,537,727	0	37,537,727	3,931	37,541,658	38,345,558	200.00
201.00		Less Observation Beds	1,407,924		1,407,924		1,407,924		201.00
202.00		Total (see instructions)	36,129,803	0	36,129,803	3,931	36,133,734	38,345,558	202.00
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00							
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		8,918,244					30.00
31.00	03100	INTENSIVE CARE UNIT		1,069,073					31.00
41.00	04100	SUBPROVIDER - I RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		1,266,348					43.00
44.00	04400	SKILLED NURSING FACILITY		0					44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	19,045,938	24,106,427	0.176357	0.000000	0.176357		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	252,217	1,978,707	0.515555	0.000000	0.516134		52.00
53.00	05300	ANESTHESIOLOGY	910,148	1,207,522	0.077028	0.000000	0.077028		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,965,492	12,957,847	0.237687	0.000000	0.237687		54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

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Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	PPS
			Outpatient	Total (col. 6 + col. 7)				
			7.00	8.00				
9.00	10.00	11.00						
60.00	06000	LABORATORY	15,363,963	18,681,587	0.187261	0.000000	0.187262	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	360,650	830,456	0.380705	0.000000	0.380705	63.00
65.00	06500	RESPIRATORY THERAPY	1,913,853	4,313,751	0.225931	0.000000	0.225931	65.00
66.00	06600	PHYSICAL THERAPY	2,062,132	2,491,401	0.293681	0.000000	0.293681	66.00
69.00	06900	ELECTROCARDIOLOGY	2,546,409	3,169,865	0.149937	0.000000	0.149937	69.00
69.01	06901	CARDIAC REHAB	231,370	231,370	0.695267	0.000000	0.695267	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,512,944	7,531,593	0.279878	0.000000	0.279878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,090,095	3,054,902	0.213032	0.000000	0.213032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,258,731	7,680,875	0.243056	0.000000	0.243056	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	11,864,554	13,593,399	0.060848	0.000000	0.060848	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,403,698	1,416,937	2.533644	0.000000	2.535574	90.00
91.00	09100	EMERGENCY	9,422,378	10,755,605	0.320725	0.000000	0.320725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,779,070	1,891,841	0.744208	0.000000	0.744208	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0.000000	93.00
93.01	04041	FAMILY PRACTICE	0	0	0.000000	0.000000	0.000000	93.01
93.02	04042	FAMILY PRACTICE	0	0	0.000000	0.000000	0.000000	93.02
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	622,624	804,074	0.535288	0.000000	0.535288	95.00
99.10	09910	CORF	0	0				99.10
200.00		Subtotal (see instructions)	89,606,266	127,951,824				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,606,266	127,951,824				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	6,845,700		6,845,700	0	0	8,918,244	30.00
31.00	03100	INTENSIVE CARE UNIT	1,282,380		1,282,380	0	0	1,069,073	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	477,669		477,669	0	0	1,266,348	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,251,332		4,251,332	0	0	5,060,489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,020,132		1,020,132	0	0	1,726,490	52.00
53.00	05300	ANESTHESIOLOGY	93,013		93,013	0	0	297,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,079,912		3,079,912	0	0	992,355	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	3,498,324		3,498,324	0	0	3,317,624	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	316,159		316,159	0	0	469,806	63.00
65.00	06500	RESPIRATORY THERAPY	974,611	0	974,611	0	0	2,399,898	65.00
66.00	06600	PHYSICAL THERAPY	731,676	0	731,676	0	0	429,269	66.00
69.00	06900	ELECTROCARDIOLOGY	475,280		475,280	0	0	623,456	69.00
69.01	06901	CARDIAC REHAB	160,864		160,864	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,107,930		2,107,930	0	0	2,018,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	650,792		650,792	0	0	1,964,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,866,881		1,866,881	0	0	4,422,144	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	827,130		827,130	0	0	1,728,845	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,590,014		3,590,014	0	0	13,239	90.00
91.00	09100	EMERGENCY	3,449,593		3,449,593	0	0	1,333,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,407,924		1,407,924	0	0	112,771	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0		0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0		0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	430,411		430,411	0	0	181,450	95.00
99.10	09910	CORF	0		0	0	0	0	99.10
200.00		Subtotal (see instructions)	37,537,727	0	37,537,727	0	0	38,345,558	200.00
201.00		Less Observation Beds	1,407,924		1,407,924	0	0		201.00
202.00		Total (see instructions)	36,129,803	0	36,129,803	0	0	38,345,558	202.00
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00							
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		8,918,244					30.00
31.00	03100	INTENSIVE CARE UNIT		1,069,073					31.00
41.00	04100	SUBPROVIDER - I RF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		1,266,348					43.00
44.00	04400	SKILLED NURSING FACILITY		0					44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	19,045,938	24,106,427	0.176357	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	252,217	1,978,707	0.515555	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	910,148	1,207,522	0.077028	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,965,492	12,957,847	0.237687	0.000000	0.000000		54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000		59.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150072

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost
			Outpatient	Total (col. 6 + col. 7)				
			7.00	8.00				
9.00	10.00	11.00						
60.00	06000	LABORATORY	15,363,963	18,681,587	0.187261	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	360,650	830,456	0.380705	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,913,853	4,313,751	0.225931	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,062,132	2,491,401	0.293681	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,546,409	3,169,865	0.149937	0.000000	0.000000	69.00
69.01	06901	CARDIAC REHAB	231,370	231,370	0.695267	0.000000	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,512,944	7,531,593	0.279878	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,090,095	3,054,902	0.213032	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,258,731	7,680,875	0.243056	0.000000	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	11,864,554	13,593,399	0.060848	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,403,698	1,416,937	2.533644	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	9,422,378	10,755,605	0.320725	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,779,070	1,891,841	0.744208	0.000000	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0.000000	93.00
93.01	04041	FAMILY PRACTICE	0	0	0.000000	0.000000	0.000000	93.01
93.02	04042	FAMILY PRACTICE	0	0	0.000000	0.000000	0.000000	93.02
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	622,624	804,074	0.535288	0.000000	0.000000	95.00
99.10	09910	CORF	0	0				99.10
200.00		Subtotal (see instructions)	89,606,266	127,951,824				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,606,266	127,951,824				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/29/2013 6:41 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	875,176	0	875,176	7,133	122.69	30.00	
31.00	INTENSIVE CARE UNIT	123,640		123,640	644	191.99	31.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	15,060		15,060	1,166	12.92	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30-199)	1,013,876		1,013,876	8,943		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,883	353,715					30.00
31.00	INTENSIVE CARE UNIT	460	88,315					31.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30-199)	3,343	442,030					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150072

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2013 6:41 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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	407,066	24,106,427	0.016886	1,488,687	25,138	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	93,632	1,978,707	0.047320	0	0	52.00
53.00	05300 ANESTHESIOLOGY	38,937	1,207,522	0.032245	72,621	2,342	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	273,242	12,957,847	0.021087	626,585	13,213	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	117,629	18,681,587	0.006297	2,127,432	13,396	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,271	830,456	0.001530	322,222	493	63.00
65.00	06500 RESPIRATORY THERAPY	78,428	4,313,751	0.018181	1,886,675	34,302	65.00
66.00	06600 PHYSICAL THERAPY	59,629	2,491,401	0.023934	345,725	8,275	66.00
69.00	06900 ELECTROCARDIOLOGY	31,080	3,169,865	0.009805	307,170	3,012	69.00
69.01	06901 CARDIAC REHAB	21,344	231,370	0.092251	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	155,903	7,531,593	0.020700	768,332	15,904	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,896	3,054,902	0.000621	1,306,042	811	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54,033	7,680,875	0.007035	2,969,686	20,892	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	84,409	13,593,399	0.006210	1,051,982	6,533	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	147,160	1,416,937	0.103858	12,246	1,272	90.00
91.00	09100 EMERGENCY	305,669	10,755,605	0.028420	902,506	25,649	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	179,993	1,891,841	0.095142	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0.000000	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0.000000	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	2,051,321	115,894,085		14,187,911	171,232	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/29/2013 6:41 pm
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Cost Center Description	Title XVIII				Hospital	
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS	
	1.00	2.00	3.00	4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	6.00	7.00	8.00	9.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,133	0.00	2,883	0	30.00
31.00	03100	INTENSIVE CARE UNIT	644	0.00	460	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	1,166	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	8,943		3,343	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150072

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	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
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150072

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	24,106,427	0.000000	0.000000	1,488,687	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,978,707	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,207,522	0.000000	0.000000	72,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,957,847	0.000000	0.000000	626,585	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	18,681,587	0.000000	0.000000	2,127,432	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	830,456	0.000000	0.000000	322,222	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,313,751	0.000000	0.000000	1,886,675	65.00
66.00	06600	PHYSICAL THERAPY	0	2,491,401	0.000000	0.000000	345,725	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,169,865	0.000000	0.000000	307,170	69.00
69.01	06901	CARDIAC REHAB	0	231,370	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,531,593	0.000000	0.000000	768,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,054,902	0.000000	0.000000	1,306,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,680,875	0.000000	0.000000	2,969,686	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	13,593,399	0.000000	0.000000	1,051,982	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,416,937	0.000000	0.000000	12,246	90.00
91.00	09100	EMERGENCY	0	10,755,605	0.000000	0.000000	902,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,891,841	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04041	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.01
93.02	04042	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.02
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	115,894,085			14,187,911	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150072

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	4,822,739	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	162,620	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,557,516	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	223,456	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	99,431	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	975,516	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	778,235	0	69.00
69.01	06901 CARDIAC REHAB	0	94,752	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,107,717	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	386,399	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,293,683	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	4,235,387	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	1,019,415	0	90.00
91.00	09100 EMERGENCY	0	2,187,315	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	876,880	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	21,821,061	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 6:41 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.176357	4,822,739	0	850,524	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.515555	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.077028	162,620	0	12,526	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237687	3,557,516	0	845,575	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.187261	223,456	0	41,845	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.380705	99,431	0	37,854	63.00
65.00	06500 RESPIRATORY THERAPY	0.225931	975,516	0	220,399	65.00
66.00	06600 PHYSICAL THERAPY	0.293681	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.149937	778,235	0	116,686	69.00
69.01	06901 CARDIAC REHAB	0.695267	94,752	0	65,878	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.279878	1,107,717	0	310,026	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.213032	386,399	0	82,315	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.243056	1,293,683	0	314,437	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0.060848	4,235,387	0	257,715	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	2.533644	1,019,415	0	2,582,835	90.00
91.00	09100 EMERGENCY	0.320725	2,187,315	0	701,527	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.744208	876,880	0	652,581	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
93.01	04041 FAMILY PRACTICE	0.000000	0	0	0	93.01
93.02	04042 FAMILY PRACTICE	0.000000	0	0	0	93.02
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.535288		0		95.00
200.00	Subtotal (see instructions)		21,821,061	0	7,092,723	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		21,821,061	0	7,092,723	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 6:41 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01 04041 FAMILY PRACTICE	0	0		93.01
93.02 04042 FAMILY PRACTICE	0	0		93.02
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2013 6:41 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,133	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,133	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)		5,666	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)		2,883	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,845,728	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)		6,845,728	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,918,244	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,918,244	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.767609	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)		1,573.99	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)		6,845,728	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		959.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,766,902	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,766,902	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 6:41 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,282,380	644	1,991.27	460	915,984	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)					3,111,557	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,794,443	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)					442,030	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					171,232	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					613,262	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,181,181	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)					1,467	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					959.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,407,924	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 6:41 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	875,176	6,845,728	0.127843	1,407,924	179,993	90.00
91.00	Nursing School cost	0	6,845,728	0.000000	1,407,924	0	91.00
92.00	Allied health cost	0	6,845,728	0.000000	1,407,924	0	92.00
93.00	All other Medical Education	0	6,845,728	0.000000	1,407,924	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2013 6:41 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,133	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,133	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)		5,666	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)		410	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)		1,166	15.00
16.00	Nursery days (title V or XIX only)		151	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,845,700	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)		6,845,700	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,918,244	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,918,244	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.767606	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)		1,573.99	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)		6,845,700	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		959.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		393,485	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)		393,485	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150072		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 6:41 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost	
Cost Center Description		1.00	2.00	3.00	4.00	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	477,669	1,166	409.66	151	61,859	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,282,380	644	1,991.27	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					460,092	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					915,436	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,467	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					959.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,407,909	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150072

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

Worksheet D-1
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description	Cost	Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)		
		1.00	2.00	3.00	4.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 6:41 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		4,242,302		30.00
31.00	03100 INTENSIVE CARE UNIT		761,466		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.176357	1,488,687	262,540	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.516134	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.077028	72,621	5,594	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.237687	626,585	148,931	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.187262	2,127,432	398,387	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.380705	322,222	122,672	63.00
65.00	06500 RESPIRATORY THERAPY	0.225931	1,886,675	426,258	65.00
66.00	06600 PHYSICAL THERAPY	0.293681	345,725	101,533	66.00
69.00	06900 ELECTROCARDIOLOGY	0.149937	307,170	46,056	69.00
69.01	06901 CARDIAC REHAB	0.695267	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.279878	768,332	215,039	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.213032	1,306,042	278,229	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.243056	2,969,686	721,800	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0.060848	1,051,982	64,011	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.535574	12,246	31,051	90.00
91.00	09100 EMERGENCY	0.320725	902,506	289,456	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.744208	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04041 FAMILY PRACTICE	0.000000	0	0	93.01
93.02	04042 FAMILY PRACTICE	0.000000	0	0	93.02
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		14,187,911	3,111,557	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		14,187,911		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 6:41 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		466,244	30.00
31.00	03100	INTENSIVE CARE UNIT		21,008	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		296,231	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.176357	510,348	90,003 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515555	348,750	179,800 52.00
53.00	05300	ANESTHESIOLOGY	0.077028	35,286	2,718 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237687	23,860	5,671 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.187261	145,039	27,160 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.380705	30,390	11,570 63.00
65.00	06500	RESPIRATORY THERAPY	0.225931	89,826	20,294 65.00
66.00	06600	PHYSICAL THERAPY	0.293681	3,947	1,159 66.00
69.00	06900	ELECTROCARDIOLOGY	0.149937	6,169	925 69.00
69.01	06901	CARDIAC REHAB	0.695267	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.279878	182,368	51,041 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.213032	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243056	212,811	51,725 73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.060848	58,951	3,587 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.533644	0	0 90.00
91.00	09100	EMERGENCY	0.320725	39,243	12,586 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.744208	2,490	1,853 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0 93.00
93.01	04041	FAMILY PRACTICE	0.000000	0	0 93.01
93.02	04042	FAMILY PRACTICE	0.000000	0	0 93.02
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,689,478	460,092 200.00
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)		1,689,478	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15U072		Date/Time Prepared: 5/29/2013 6:41 pm	
		Title XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.176357	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515555	0	52.00
53.00	05300	ANESTHESIOLOGY	0.077028	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.237687	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.187261	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.380705	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.225931	0	65.00
66.00	06600	PHYSICAL THERAPY	0.293681	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149937	0	69.00
69.01	06901	CARDIAC REHAB	0.695267	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.279878	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.213032	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243056	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.060848	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.533644	0	90.00
91.00	09100	EMERGENCY	0.320725	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.744208	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
93.01	04041	FAMILY PRACTICE	0.000000	0	93.01
93.02	04042	FAMILY PRACTICE	0.000000	0	93.02
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 6:41 pm
		Title VIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		4,816,666	1.00
2.00	Outlier payments for discharges. (see instructions)		90,853	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)		78.99	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.73	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		22.70	31.00
32.00	Sum of lines 30 and 31		26.43	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		578,000	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		5,485,519	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		7,138,002	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		7,138,002	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		402,675	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 6:41 pm
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			7,540,677 59.00
60.00	Primary payer payments			3,957 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			7,536,720 61.00
62.00	Deductibles billed to program beneficiaries			713,108 62.00
63.00	Coinurance billed to program beneficiaries			6,358 63.00
64.00	Allowable bad debts (see instructions)			-1,470 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			-1,029 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-8,936 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6,816,225 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			493 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			705,758 70.96
70.97	Low Volume Payment-2			244,131 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)			7,766,607 71.00
72.00	Interim payments			7,656,287 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)			110,320 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			262,072 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 6:41 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,092,723	2.00
3.00	PPS payments		5,184,788	3.00
4.00	Outlier payment (see instructions)		24,320	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.829	5.00
6.00	Line 2 times line 5		5,879,867	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		88.59	7.00
8.00	Transitional corridor payment (see instructions)		570,145	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		5,779,253	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,324,687	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)		4,454,566	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)		4,454,566	30.00
31.00	Primary payer payments		1,191	31.00
32.00	Subtotal (line 30 minus line 31)		4,453,375	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		49,812	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		34,868	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		31,374	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,488,243	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-24	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		4,488,267	40.00
41.00	Interim payments		4,645,569	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)		-157,302	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150072

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2013 6:41 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		7,296,844		3,883,254	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		244,131		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	01/01/2012	115,312	01/01/2012	148,998	3.01
3.02			0	11/01/2012	501,487	3.02
3.03			0	12/03/2012	37,970	3.03
3.04			0	12/31/2012	73,860	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)		115,312		762,315	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)		7,656,287		4,645,569	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		110,320		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		157,302	6.02
7.00	Total Medicare program liability (see instructions)		7,766,607		4,488,267	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150072

Period:

Worksheet E-1

Component CCN: 15U072

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

Part I
Date/Time Prepared:
5/29/2013 6:41 pm

Title XVIII

Swing Beds - SNF

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150072

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

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2013 6:41 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,983 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,343 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			326 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			6,310 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			127,951,824 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,603,761 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)			1,285,989 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,246,499 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			39,490 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150072

Period:

Worksheet E-2

Component CCN: 15U072

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

Date/Time Prepared:
5/29/2013 6:41 pm

Title XVIII

Swing Beds - SNF

PPS

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	0	0	19.00
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150072

Period:

Worksheet E-2

Component CCN: 15U072

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

Date/Time Prepared:
5/29/2013 6:41 pm

		Title XIX	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Reimbursable bad debts (see instructions)		0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0	19.00
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 6:41 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		915,436		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		915,436	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		915,436	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		783,483		8.00
9.00	Ancillary service charges		1,689,478	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,472,961	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,472,961	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,557,525	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		915,436	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		915,436	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		915,436	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		915,436	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		915,436	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		915,436	0	40.00
41.00	Interim payments		1,216,336	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-300,900		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0		43.00

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

Provider CCN: 150072

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

Worksheet G

Date/Time Prepared:
5/29/2013 6:41 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	12,965,624	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	8,661,754	0	0	0	4.00
5.00	Other receivable	51,326	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	4,194,680	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)	25,873,384	0	0	0	11.00
FIXED ASSETS						
12.00	Land	694,967	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	37,214,008	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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)	37,908,975	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	10,133,993	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	1,377,880	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,511,873	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,294,232	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,507,368	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,531,409	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,842,091	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	856,618	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,737,486	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,786,333	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	377,899	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,164,232	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,901,718	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	50,392,514				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)	50,392,514	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,294,232	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150072

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

Worksheet G-1

Date/Time Prepared:
5/29/2013 6:41 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		41,726,451		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,666,063			2.00
3.00	Total (sum of line 1 and line 2)		50,392,514		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)		50,392,514		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		50,392,514		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150072

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2013 6:41 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,186,502		10,186,502	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,186,502		10,186,502	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,158,599		1,158,599	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)	1,158,599		1,158,599	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,345,101		11,345,101	17.00
18.00	Ancillary services	25,483,670	76,745,146	102,228,816	18.00
19.00	Outpatient services	1,581,047	17,739,366	19,320,413	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	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	16,825,802	16,825,802	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	38,409,818	111,310,314	149,720,132	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,816,019		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		56,816,019		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150072

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

Worksheet G-3

Date/Time Prepared:
5/29/2013 6:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	149,720,132	1.00
2.00	Less contractual allowances and discounts on patients' accounts	88,439,167	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,280,965	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,816,019	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,464,946	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	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 REVENUE	3,432,694	24.00
24.01	INVESTMENT INCOME	121,343	24.01
24.02	GAIN (LOSS) ON SALE OF EQUIPMENT	-39,480	24.02
24.03	ADJUSTMENT	686,675	24.03
24.04	OTHER INCOME RECONCILING ITEM	-115	24.04
25.00	Total other income (sum of lines 6-24)	4,201,117	25.00
26.00	Total (line 5 plus line 25)	8,666,063	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,666,063	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150072	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/29/2013 6:41 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		382,868	1.00
2.00	Capital DRG outlier payments		19,807	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		17.24	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)		402,675	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00