

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: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 2:41 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 checked="" type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2013 Time: 2:41 pm
Contractor use only	5. <input checked="" 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 checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input checked="" 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 ST. ELIZABETH EAST (150109) 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	-509,031	-98,935	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	67,000	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	-442,031	-98,935	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 2:40 pm
---	--	----------------------	---	---

1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00			
1.00	Street: 1701 SOUTH CREAMY LANCE	PO Box:	Zip Code: 47905-		County: TIPPECANOE				1.00
2.00	City: LAFAYETTE	State: IN							2.00

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

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. ELIZABETH EAST	150109	29140	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ST. ELIZABETH REHAB UNIT	15T109	29140	5	01/01/1995	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	ST. ELIZABETH HHA	157124	29140		07/06/1966	N	P	N	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)	1		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,796	733	22	0	5,743	77	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.	258	24	0	0	0	0	25.00

						Urban/Rural S	Date of Geogr		
						1.00	2.00		

26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 2:40 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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)		0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 2:40 pm
---	--	----------------------	---	---

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 2:40 pm		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				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)	N	N	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		Y		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)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00			2.00 3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 2:40 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	928,000	454,501		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	158014	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: FRANCISCAN ALLIANCE, INC.	Contractor's Name: WPS		Contractor's Number: 08101	
142.00	Street: 1515 DRAGOON TRAIL	PO Box: 1290			
143.00	City: MISHAWAKA	State: IN		Zip Code: 46546-1290	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y	145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150109			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 2:40 pm		
							1.00		
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00		166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00		169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 2:40 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
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	04/17/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00		2.00	
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	03/06/2013	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: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 2:40 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	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.			Y	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.	JEFF	DEAKYNE		41.00
42.00	Enter the employer/company name of the cost report preparer.	FSEH - EAST			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5928	JEFF.DEAKYNE@FRANCISCANALLIANCE.ORG		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)	03/06/2013	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.	DIVISION DIRECTOR OF FINANCE	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: 150109

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2013 2:40 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	138	50,508	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)		138	50,508	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	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 NEONATAL INTENSIVE CARE UNIT	35.00	14	5,124	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		164	60,024	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		182				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
Component	I/P Days / O/P Vi s i t s / Tri ps			Full Time Equivalents		
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	11,271	3,628	27,787			1.00
2.00 HMO	1,633	5,743				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)	11,271	3,628	27,787			7.00
8.00 INTENSIVE CARE UNIT	1,503	0	2,659			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 NEONATAL INTENSIVE CARE UNIT	0	0	3,553			12.00
13.00 NURSERY	0	0	1,306			13.00
14.00 Total (see instructions)	12,774	3,628	35,305	0.00	1,049.34	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	1,801	230	3,140	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	11,028	0	15,330	0.00	0.00	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: 150109

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,049.34	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	2,688			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	3,211	1,365	8,621	1.00
2.00	HMO			409			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	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3,211	1,365	8,621	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	155	19	266	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150109

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2013 2:40 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	55,000,084	6,588,161	61,588,245	2,182,628.00	28.22
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,447,829	0	3,447,829	121,038.00	28.49
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		451,754	0	451,754	6,224.87	72.57
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,428,294	0	1,428,294	19,580.00	72.95
14.00	Home office salaries & wage-related costs		9,496,561	0	9,496,561	189,550.00	50.10
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		19,444,531	0	19,444,531		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		2,250,797	0	2,250,797		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	936,741	-338,508	598,233	27,163.00	22.02
27.00	Administrative & General	5.00	5,384,914	2,554,573	7,939,487	305,268.00	26.01
28.00	Administrative & General under contract (see inst.)		4,419	0	4,419	152.00	29.07
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,790,095	616,946	2,407,041	122,325.00	19.68
31.00	Laundry & Linen Service	8.00	0	114,705	114,705	8,997.00	12.75
32.00	Housekeeping	9.00	1,236,648	0	1,236,648	97,934.00	12.63
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,218,408	-593,014	625,394	40,874.00	15.30
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	433,020	593,014	1,026,034	72,771.00	14.10
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	2,424,305	-383,040	2,041,265	56,048.00	36.42
39.00	Central Services and Supply	14.00	451,255	0	451,255	27,764.00	16.25
40.00	Pharmacy	15.00	2,217,170	0	2,217,170	62,084.00	35.71
41.00	Medical Records & Medical Records Library	16.00	1,267,091	-147,889	1,119,202	55,731.00	20.08

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150109

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2013 2:40 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	583,536	-92,199	491,337	19,861.00	24.74	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: 150109

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2013 2:40 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,004,503	6,588,161	61,592,664	2,182,780.00	28.22	1.00
2.00	Excluded area salaries (see instructions)	3,447,829	0	3,447,829	121,038.00	28.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	51,556,674	6,588,161	58,144,835	2,061,742.00	28.20	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,376,609	0	11,376,609	215,354.87	52.83	4.00
5.00	Subtotal wage-related costs (see inst.)	19,444,531	0	19,444,531	0.00	33.44	5.00
6.00	Total (sum of lines 3 thru 5)	82,377,814	6,588,161	88,965,975	2,277,096.87	39.07	6.00
7.00	Total overhead cost (see instructions)	17,947,602	2,324,588	20,272,190	896,972.00	22.60	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2013 2:40 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)		6,001,119	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		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)		10,615,583	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		366,199	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		70,477	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)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		122,614	14.00
15.00	'Workers' Compensation Insurance		114,338	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		3,503,754	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		123,017	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		133,208	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		21,050,309	24.00
Part B - Other than Core Related Cost				
25.00	EMPLOYEE ASSISTANCE		645,019	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/29/2013 2:40 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		451,754	21,695,328
2.00	Hospital		451,754	19,444,531
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA		0	0
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC		0	0
15.00	Hospital-Based Health Clinic FQHC		0	0
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
17.00	Renal Dialysis		0	0
18.00	Other		0	2,250,797

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150109 Component CCN: 157124		Period: From 01/01/2012 To 12/31/2012		Worksheet S-4 Date/Time Prepared: 5/29/2013 2:40 pm		
				Home Health Agency I		PPS		
				1.00				
0.00	County	TIPPEECANOE				0.00		
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	1,907	13	219	2,139	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	564.00	20.00	94.00	678.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel				12.10	0.00	12.10	5.00
6.00	Direct Nursing Service				7.37	0.00	7.37	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				1.57	0.00	1.57	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				0.11	0.00	0.11	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				0.20	0.00	0.20	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00
14.00	Medical Social Service				0.39	0.00	0.39	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				1.42	0.00	1.42	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00
18.00	INFUSION				6.36	0.00	6.36	18.00
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	29140						20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	3.00	4.00	5.00		
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	4,559	22	119	34	4,734	21.00	
22.00	Skilled Nursing Visit Charges	1,367,091	6,600	35,783	10,200	1,419,674	22.00	
23.00	Physical Therapy Visits	3,242	0	16	41	3,299	23.00	
24.00	Physical Therapy Visit Charges	1,000,988	0	4,960	12,710	1,018,658	24.00	
25.00	Occupational Therapy Visits	1,001	0	4	9	1,014	25.00	
26.00	Occupational Therapy Visit Charges	310,310	0	1,240	2,790	314,340	26.00	
27.00	Speech Pathology Visits	75	0	0	0	75	27.00	
28.00	Speech Pathology Visit Charges	23,142	0	0	0	23,142	28.00	
29.00	Medical Social Service Visits	99	0	3	2	104	29.00	
30.00	Medical Social Service Visit Charges	35,507	0	1,080	720	37,307	30.00	
31.00	Home Health Aide Visits	1,745	42	4	11	1,802	31.00	
32.00	Home Health Aide Visit Charges	252,089	6,090	580	1,595	260,354	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	10,721	64	146	97	11,028	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,989,127	12,690	43,643	28,015	3,073,475	35.00	
36.00	Total Number of Episodes (standard/non outlier)	577		54	9	640	36.00	
37.00	Total Number of Outlier Episodes		1		0	1	37.00	
38.00	Total Non-Routine Medical Supply Charges	333,831	1,254	14,408	0	349,493	38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/29/2013 2:40 pm
---	----------------------	---	--

				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)		0.291762		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		11,367,052		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		78,067,494		6.00
7.00	Medicaid cost (line 1 times line 6)		22,777,128		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)		11,410,076		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)		11,410,076		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	30,373,510	3,006,955	33,380,465	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	8,861,836	877,315	9,739,151	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)	8,861,836	877,315	9,739,151	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)		7,797,420		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		300,314		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		7,497,106		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,187,371		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		11,926,522		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		23,336,598		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150109

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

Worksheet A
Date/Time Prepared:
5/29/2013 2:40 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		15,407,957	15,407,957	4,719,821	20,127,778	1.00
2.00	00200		0	0	2,616,397	2,616,397	2.00
4.00	00400				-314	35,576,748	4.00
5.01	00510	936,741	34,640,321	35,577,062	0	819,261	5.01
5.02	00511	0	819,261	819,261	0	13,406,051	5.02
5.02	00511	29,370	13,376,681	13,406,051	0	1,192,902	5.03
5.03	00512	589,137	603,765	1,192,902	0	0	5.04
5.04	00513	0	0	0	0	0	5.05
5.05	00514	0	0	0	0	0	5.06
5.06	00560	4,766,407	29,564,318	34,330,725	-493,871	8,884,783	7.00
7.00	00700	1,790,095	7,104,808	8,894,903	-10,120	0	8.00
8.00	00800	0	0	0	0	0	9.00
9.00	00900	1,236,648	439,363	1,676,011	-853	1,675,158	10.00
10.00	01000	1,218,408	414,930	1,633,338	-640,638	992,700	11.00
11.00	01100	433,020	554,985	988,005	591,397	1,579,402	12.00
13.00	01300	2,424,305	75,052	2,499,357	-333	2,499,024	13.00
14.00	01400	451,255	1,238,133	1,689,388	-1,147,010	542,378	14.00
15.00	01500	2,217,170	4,815,631	7,032,801	-4,054,790	2,978,011	15.00
16.00	01600	1,267,091	606,725	1,873,816	0	1,873,816	16.00
17.00	01700	583,536	3,629	587,165	0	587,165	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,505,252	1,757,593	15,262,845	-5,212,149	10,050,696	30.00
31.00	03100	287,150	2,504	289,654	-496	289,158	31.00
35.00	02040	1,826,534	403,517	2,230,051	-106,995	2,123,056	35.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	989,343	142,596	1,131,939	-41,191	1,090,748	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	11,083	11,083	471,395	482,478	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,426,602	40,162,414	43,589,016	-20,083,304	23,505,712	50.00
51.00	05100	701,086	21,434	722,520	-18,796	703,724	51.00
52.00	05200	0	764	764	3,469,784	3,470,548	52.00
54.00	05400	3,793,848	15,536,007	19,329,855	-2,147,312	17,182,543	54.00
56.00	05600	1,097,697	3,664,462	4,762,159	-3,483,845	1,278,314	56.00
60.00	06000	63,602	6,193,658	6,257,260	-122,385	6,134,875	60.00
65.00	06500	1,196,420	373,712	1,570,132	-217,806	1,352,326	65.00
66.00	06600	801,537	31,571	833,108	-14,973	818,135	66.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	566,803	103,774	670,577	-22,071	648,506	69.00
70.00	07000	471,399	169,249	640,648	-29,088	611,560	70.00
71.00	07100	0	0	0	14,451,391	14,451,391	71.00
72.00	07200	0	0	0	13,968,342	13,968,342	72.00
73.00	07300	0	0	0	4,360,360	4,360,360	73.00
73.01	07301	284,008	38,483	322,491	-25,031	297,460	73.01
74.00	07400	0	0	0	0	0	74.00
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09001	0	175,328	175,328	-74,867	100,461	90.00
91.00	09100	5,037,896	1,320,395	6,358,291	-819,954	5,538,337	91.00
92.00	09200						92.00
92.01	09201	549,238	257,111	806,349	-249,322	557,027	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	2,341,429	935,500	3,276,929	0	3,276,929	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300		7,439,792	7,439,792	-5,631,373	1,808,419	113.00
118.00		54,883,027	188,406,506	243,289,533	0	243,289,533	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	33,761	33,761	0	33,761	190.00
192.00	19200	0	39	39	0	39	192.00
194.00	07950	109,735	-30	109,705	0	109,705	194.00
194.01	07951	7,322	34,061	41,383	0	41,383	194.01
200.00		55,000,084	188,474,337	243,474,421	0	243,474,421	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150109

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

Worksheet A
Date/Time Prepared:
5/29/2013 2:40 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	-8,799,032	11,328,746	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	5,663,982	8,280,379	2.00
4.00	00400	EMPLOYEE BENEFITS	-12,858,854	22,717,894	4.00
5.01	00510	COMMUNICATIONS	475,421	1,294,682	5.01
5.02	00511	MGMT INFO SYSTEMS	-11,990,070	1,415,981	5.02
5.03	00512	PURCHASING	-396,238	796,664	5.03
5.04	00513	ADMINISTRATIVE	422,639	422,639	5.04
5.05	00514	PATIENT ACCOUNTING	2,489,682	2,489,682	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-9,939,782	23,897,072	5.06
7.00	00700	OPERATION OF PLANT	-447,966	8,436,817	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	644,850	644,850	8.00
9.00	00900	HOUSEKEEPING	0	1,675,158	9.00
10.00	01000	DIETARY	-33,672	959,028	10.00
11.00	01100	CAFETERIA	-843,755	735,647	11.00
13.00	01300	NURSING ADMINISTRATION	-394,898	2,104,126	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	542,378	14.00
15.00	01500	PHARMACY	128,736	3,106,747	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-194,692	1,679,124	16.00
17.00	01700	SOCIAL SERVICE	-92,772	494,393	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,354,185	13,404,881	30.00
31.00	03100	INTENSIVE CARE UNIT	0	289,158	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	-207,986	1,915,070	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	-46	1,090,702	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	482,478	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	23,505,712	50.00
51.00	05100	RECOVERY ROOM	0	703,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,470,548	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22,662	17,159,881	54.00
56.00	05600	RADIOISOTOPE	0	1,278,314	56.00
60.00	06000	LABORATORY	-192,213	5,942,662	60.00
65.00	06500	RESPIRATORY THERAPY	-29,493	1,322,833	65.00
66.00	06600	PHYSICAL THERAPY	2,136,275	2,954,410	66.00
68.00	06800	SPEECH PATHOLOGY	246,881	246,881	68.00
69.00	06900	ELECTROCARDIOLOGY	-34,548	613,958	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-837,144	-225,584	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,875,796	12,575,595	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	-72,966	13,895,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,360,360	73.00
73.01	07301	DIABETES CENTER	0	297,460	73.01
74.00	07400	RENAL DIALYSIS	425,633	425,633	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08801	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09001	CLINIC	-66,954	33,507	90.00
91.00	09100	EMERGENCY	-404,642	5,133,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	557,027	92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-6,006	3,270,923	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	-1,808,419	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-35,562,322	207,727,211	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,761	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39	192.00
194.00	07950	MOB	0	109,705	194.00
194.01	07951	LIFELINE	0	41,383	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-35,562,322	207,912,099	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BUILDING RENTAL					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,453,520	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
TOTALS			0	1,453,520	
B - EQUIPMENT RENTAL					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	182,035	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
TOTALS			0	182,035	
C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,451,391	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	13,968,342	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
TOTALS			0	28,419,733	
D - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,360,360	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
TOTALS			0	4,360,360	
E - LDRP					
1.00	NURSERY	43.00	462,924	8,501	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,407,214	62,570	2.00
TOTALS			3,870,138	71,071	

RECLASSIFICATIONS

Provider CCN: 150109

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

Worksheet A-6

Date/Time Prepared:
5/29/2013 2:40 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
F - CAFETERIA						
1.00	CAFETERIA	11.00	593,014	47,624	1.00	
	TOTALS		593,014	47,624		
G - CAPITAL EXP (INT & DEP)						
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	69,290	1.00	
	EQUIP					
	TOTALS		0	69,290		
H - FSEH SHARED SERVICES						
1.00	COMMUNICATIONS	5.01	409,536	0	1.00	
2.00	ADMINISTRATIVE	5.04	416,044	0	2.00	
3.00	PATIENT ACCOUNTING	5.05	860,594	0	3.00	
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	1,450,468	0	4.00	
5.00	OPERATION OF PLANT	7.00	1,083,461	0	5.00	
6.00	LAUNDRY & LINEN SERVICE	8.00	114,705	0	6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	52,311	0	7.00	
8.00	ELECTROCARDIOLOGY	69.00	358,356	0	8.00	
9.00	EMPLOYEE BENEFITS	4.00	0	338,508	9.00	
10.00	MGMT INFO SYSTEMS	5.02	0	3,175	10.00	
11.00	PURCHASING	5.03	0	63,681	11.00	
12.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	515,213	12.00	
13.00	OPERATION OF PLANT	7.00	0	466,515	13.00	
14.00	NURSING ADMINISTRATION	13.00	0	383,040	14.00	
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	200,200	15.00	
16.00	SOCIAL SERVICE	17.00	0	92,199	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	11,370	17.00	
18.00	PHYSICAL THERAPY	66.00	0	113,884	18.00	
19.00	EMERGENCY	91.00	0	24,326	19.00	
	TOTALS		4,745,475	2,212,111		
I - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,266,301	1.00	
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	2,365,072	2.00	
	EQUIP					
	TOTALS		0	5,631,373		
J - PURCHASED SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	3,112,886	0	1.00	
2.00	LABORATORY	60.00	0	27,218	2.00	
3.00	PHYSICAL THERAPY	66.00	2,084,574	0	3.00	
4.00	SPEECH PATHOLOGY	68.00	234,634	0	4.00	
5.00	ELECTROCARDIOLOGY	69.00	0	614,732	5.00	
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	735,347	6.00	
	TOTALS		5,432,094	1,377,297		
500.00	Grand Total: Increases		14,640,721	43,824,414	500.00	

RECLASSIFICATIONS

Provider CCN: 150109

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

Worksheet A-6
Date/Time Prepared:
5/29/2013 2:40 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - BUILDING RENTAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	493,211	10	1.00
2.00	CAFETERIA	11.00	0	48,949	10	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	256,141	10	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	427,436	10	4.00
5.00	DIABETES CENTER	73.01	0	20,674	10	5.00
6.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	207,109	10	6.00
	TOTALS		0	1,453,520		
B - EQUIPMENT RENTAL						
1.00	EMPLOYEE BENEFITS	4.00	0	314	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	660	10	2.00
3.00	OPERATION OF PLANT	7.00	0	10,120	10	3.00
4.00	HOUSEKEEPING	9.00	0	853	10	4.00
5.00	CAFETERIA	11.00	0	292	10	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,713	10	6.00
7.00	PHARMACY	15.00	0	50,617	10	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	16,265	10	8.00
9.00	OPERATING ROOM	50.00	0	54,993	10	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	440	10	10.00
11.00	RADIOISOTOPE	56.00	0	29,306	10	11.00
12.00	RESPIRATORY THERAPY	65.00	0	12,862	10	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,350	10	13.00
14.00	EMERGENCY	91.00	0	250	10	14.00
15.00		0.00	0	0	10	15.00
	TOTALS		0	182,035		
C - MEDICAL SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	333	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,142,641	0	2.00
3.00	PHARMACY	15.00	0	71,860	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	939,605	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	496	0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	90,977	0	6.00
7.00	SUBPROVIDER - IRF	41.00	0	38,728	0	7.00
8.00	OPERATING ROOM	50.00	0	19,807,792	0	8.00
9.00	RECOVERY ROOM	51.00	0	18,320	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,619,164	0	10.00
11.00	RADIOISOTOPE	56.00	0	3,448,962	0	11.00
12.00	LABORATORY	60.00	0	122,385	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	202,492	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	14,973	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	21,611	0	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	27,204	0	16.00
17.00	DIABETES CENTER	73.01	0	4,357	0	17.00
18.00	CLINIC	90.00	0	24,860	0	18.00
19.00	EMERGENCY	91.00	0	782,708	0	19.00
20.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	40,265	0	20.00
	TOTALS		0	28,419,733		
D - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	656	0	1.00
2.00	PHARMACY	15.00	0	3,932,313	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	58,929	0	3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	16,018	0	4.00
5.00	SUBPROVIDER - IRF	41.00	0	2,463	0	5.00
6.00	NURSERY	43.00	0	30	0	6.00
7.00	OPERATING ROOM	50.00	0	220,519	0	7.00
8.00	RECOVERY ROOM	51.00	0	476	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,982	0	9.00
10.00	RADIOISOTOPE	56.00	0	5,577	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	2,452	0	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	460	0	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	534	0	13.00
14.00	CLINIC	90.00	0	50,007	0	14.00
15.00	EMERGENCY	91.00	0	36,996	0	15.00
16.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	1,948	0	16.00
	TOTALS		0	4,360,360		
E - LDRP						
1.00	ADULTS & PEDIATRICS	30.00	3,870,138	71,071	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		3,870,138	71,071		

RECLASSIFICATIONS

Provider CCN: 150109

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

Worksheet A-6

Date/Time Prepared:
5/29/2013 2:40 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
F - CAFETERIA							
1.00	DIETARY	10.00	593,014	47,624	0		1.00
	TOTALS		593,014	47,624			
G - CAPITAL EXP (INT & DEP)							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	69,290	9		1.00
	TOTALS		0	69,290			
H - FSEH SHARED SERVICES							
1.00	COMMUNICATIONS	5.01	0	409,536	0		1.00
2.00	ADMINISTRATIVE	5.04	0	416,044	0		2.00
3.00	PATIENT ACCOUNTING	5.05	0	860,594	0		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,450,468	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,083,461	0		5.00
6.00	LAUNDRY & LINEN SERVICE	8.00	0	114,705	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	52,311	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	358,356	0		8.00
9.00	EMPLOYEE BENEFITS	4.00	338,508	0	0		9.00
10.00	MGMT INFO SYSTEMS	5.02	3,175	0	0		10.00
11.00	PURCHASING	5.03	63,681	0	0		11.00
12.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	515,213	0	0		12.00
13.00	OPERATION OF PLANT	7.00	466,515	0	0		13.00
14.00	NURSING ADMINISTRATION	13.00	383,040	0	0		14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	200,200	0	0		15.00
16.00	SOCIAL SERVICE	17.00	92,199	0	0		16.00
17.00	RESPIRATORY THERAPY	65.00	11,370	0	0		17.00
18.00	PHYSICAL THERAPY	66.00	113,884	0	0		18.00
19.00	EMERGENCY	91.00	24,326	0	0		19.00
	TOTALS		2,212,111	4,745,475			
I - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	5,631,373	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	5,631,373			
J - PURCHASED SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	3,112,886	0		1.00
2.00	LABORATORY	60.00	27,218	0	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	2,084,574	0		3.00
4.00	SPEECH PATHOLOGY	68.00	0	234,634	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	614,732	0	0		5.00
6.00	ELECTROENCEPHALOGRAPHY	70.00	735,347	0	0		6.00
	TOTALS		1,377,297	5,432,094			
500.00	Grand Total: Decreases		8,052,560	50,412,575			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150109

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2013 2:40 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	8,484,796	0	0	0	3,415,415	1.00
2.00	Land Improvements	5,471,594	0	0	0	2,942,339	2.00
3.00	Buildings and Fixtures	269,532,491	0	0	0	79,616,930	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	77,937,638	0	0	0	3,558,389	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	361,426,519	0	0	0	89,533,073	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	361,426,519	0	0	0	89,533,073	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,069,381	0				1.00
2.00	Land Improvements	2,529,255	0				2.00
3.00	Buildings and Fixtures	189,915,561	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	74,379,249	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	271,893,446	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	271,893,446	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150109

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2013 2:40 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	15,407,957	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,407,957	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	15,407,957				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	15,407,957				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150109

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2013 2:40 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
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	6,685,675	1,453,520	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	5,788,845	182,035	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,474,520	1,635,555	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,189,551	0	0	0	11,328,746	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,309,499	0	0	0	8,280,379	2.00
3.00	Total (sum of lines 1-2)	5,499,050	0	0	0	19,609,125	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150109

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

Worksheet A-8

Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-76,750	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-55,573	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-982,206			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	-31,873,222			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-820,619	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	B	-23,136	CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		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	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MARKETING EXP	A	-46	SUBPROVIDER - IRF	41.00	0	33.00
33.01 MARKETING EXP	A	-2,407	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01

Provider CCN: 150109

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

Worksheet A-8

Date/Time Prepared:
 5/29/2013 2:40 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
33.02	MARKETING EXP	A	-5,766	HOME HEALTH AGENCY	101.00	0	33.02
33.03	ADVERTISING EXP	A	-510	DIETARY	10.00	0	33.03
33.04	ADVERTISING EXP	A	-2,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	ADVERTISING EXP	A	-240	HOME HEALTH AGENCY	101.00	0	33.05
33.06	PROPERTY RECEIPTS	B	-48,139	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.06
33.07	SILVER RECOVERY	B	-23,895	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.07
33.08	BLDG RENT REV - CLARIAN ARNETT BLDG	B	-286,592	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	BLDG RENT REV	B	-162,759	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	NCHS BLDG MGMT REV	B	-3,980	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	MAINTENANCE/SECURITY REV	B	-91,870	OPERATION OF PLANT	7.00	0	33.11
33.12	MAINTENANCE/SECURITY REV	B	-20,442	OPERATION OF PLANT	7.00	0	33.12
33.13	EXP ALLOC -- SCMC PHYSICIANS	B	-761,000	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.13
33.14	MISCELLANEOUS - OTHER OPERATING	B	-66,954	CLINIC	90.00	0	33.14
33.15	CAFETERIA REV	B	-1,002	DIETARY	10.00	0	33.15
33.16	MISC REV	B	-32,160	DIETARY	10.00	0	33.16
33.17	EDUCATION REV	B	-82,839	EMERGENCY	91.00	0	33.17
33.18	TEXT BOOK REVENUE	B	-5,701	EMERGENCY	91.00	0	33.18
33.19	MISC REV	B	-5,100	EMERGENCY	91.00	0	33.19
33.20	GENERAL DONATION	B	1,250	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21	FSEH - CENTRAL ADJ	A	-76,613	PHARMACY	15.00	0	33.21
33.22	FSEH - CENTRAL ADJ	A	-52,051	ADULTS & PEDIATRICS	30.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-35,562,322				50.00

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

Provider CCN: 150109

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2013 2: 40 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	FRANCIS CAN DEPRECIATION	1,291,171	0
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	FRANCIS CAN DEPRECIATION	934,915	0
3.00	113.00	INTEREST EXPENSE	FRANCIS CAN INTEREST	5,631,373	0
4.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	FRANCIS CAN A&G	14,881,448	0
4.01	15.00	PHARMACY	FRANCIS CAN COEP	628,087	0
4.02	5.02	MGMT INFO SYSTEMS	INTERCO ASSESSMENTS - AIS	0	11,818,463
4.03	5.03	PURCHASING	INTERCO ASSESSMENTS - CENTRAL PROCUR	0	299,688
4.04	5.06	OTHER ADMINISTRATIVE AND GENERAL	INTERCO ASSESSMENTS - CORP/AIS	0	4,678,000
4.05	15.00	PHARMACY	INTERCO ASSESSMENTS - AIS	0	421,211
4.06	113.00	INTEREST EXPENSE	DEBT SERVICE ASSESSMENT	0	7,439,792
4.07	1.00	NEW CAP REL COSTS-BLDG & FIXT	FSEH-E SHARED SERVICES	0	16,167,989
4.08	1.00	NEW CAP REL COSTS-BLDG & FIXT	FSEH-E SHARED SERVICES	6,607,867	0
4.09	2.00	NEW CAP REL COSTS-MVBLE EQUIP	FSEH-E SHARED SERVICES	4,784,640	0
4.10	4.00	EMPLOYEE BENEFITS	FSEH-E SHARED SERVICES	22,718,209	35,577,063
4.11	5.01	COMMUNICATIONS	FSEH-E SHARED SERVICES	730,705	819,261
4.12	5.02	MGMT INFO SYSTEMS	FSEH-E SHARED SERVICES	1,415,981	1,587,588
4.13	5.03	PURCHASING	FSEH-E SHARED SERVICES	796,664	893,214
4.14	5.06	OTHER ADMINISTRATIVE AND GENERAL	FSEH-E SHARED SERVICES	8,248,139	28,250,940
4.15	7.00	OPERATION OF PLANT	FSEH-E SHARED SERVICES	6,576,813	8,894,903
4.16	13.00	NURSING ADMINISTRATION	FSEH-E SHARED SERVICES	2,104,458	2,499,356
4.17	16.00	MEDICAL RECORDS & LIBRARY	FSEH-E SHARED SERVICES	1,534,212	1,873,831
4.18	17.00	SOCIAL SERVICE	FSEH-E SHARED SERVICES	494,393	587,165
4.19	65.00	RESPIRATORY THERAPY	FSEH-E SHARED SERVICES	61,778	73,370
4.20	66.00	PHYSICAL THERAPY	FSEH-E SHARED SERVICES	616,739	732,468
4.21	91.00	EMERGENCY	FSEH-E SHARED SERVICES	129,643	153,970
4.22	5.01	COMMUNICATIONS	FSEH-C SHARED SERVICES	563,977	0
4.23	5.04	ADMINISTRATIVE	FSEH-C SHARED SERVICES	422,639	0
4.24	5.05	PATIENT ACCOUNTING	FSEH-C SHARED SERVICES	2,489,682	0
4.25	5.06	OTHER ADMINISTRATIVE AND GENERAL	FSEH-C SHARED SERVICES	1,309,703	0
4.26	7.00	OPERATION OF PLANT	FSEH-C SHARED SERVICES	1,982,436	0
4.27	8.00	LAUNDRY & LINEN SERVICE	FSEH-C SHARED SERVICES	644,850	0
4.28	16.00	MEDICAL RECORDS & LIBRARY	FSEH-C SHARED SERVICES	144,927	0
4.29	69.00	ELECTROCARDIOLOGY	FSEH-C SHARED SERVICES	657,263	0
4.30	30.00	ADULTS & PEDIATRICS	FSEH PURCHASED SERVICES	3,406,236	0
4.31	60.00	LABORATORY	FSEH PURCHASED SERVICES	0	149,862
4.32	66.00	PHYSICAL THERAPY	FSEH PURCHASED SERVICES	2,252,004	0
4.33	68.00	SPEECH PATHOLOGY	FSEH PURCHASED SERVICES	246,881	0
4.34	69.00	ELECTROCARDIOLOGY	FSEH PURCHASED SERVICES	0	690,631
4.35	70.00	ELECTROENCEPHALOGRAPHY	FSEH PURCHASED SERVICES	0	835,464
4.36	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	FSEH PURCHASED SERVICES	0	1,875,796
4.37	72.00	IMPL. DEV. CHARGED TO PATIENT	FSEH PURCHASED SERVICES	0	72,966
4.38	74.00	RENAL DIALYSIS	FSEH PURCHASED SERVICES	425,633	0
4.39	91.00	EMERGENCY	ED TRAINING	0	213,697
4.40	0.00			0	0
5.00	0			94,733,466	126,606,688

* 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.

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

Provider CCN: 150109

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2013 2:40 pm

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

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	G		0.00	ST. ELIZABETH C	0.00	6.00
7.00	B	FRANCISCAN ALLI	100.00		0.00	7.00
8.00	C		0.00	INNERVISION IMA	0.00	8.00
9.00	C		0.00	UNITY SURGICAL	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: 150109

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2013 2:40 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	1,291,171	9		1.00
2.00	934,915	9		2.00
3.00	5,631,373	11		3.00
4.00	14,881,448	0		4.00
4.01	628,087	0		4.01
4.02	-11,818,463	0		4.02
4.03	-299,688	0		4.03
4.04	-4,678,000	0		4.04
4.05	-421,211	0		4.05
4.06	-7,439,792	0		4.06
4.07	-16,167,989	9		4.07
4.08	6,607,867	9		4.08
4.09	4,784,640	9		4.09
4.10	-12,858,854	0		4.10
4.11	-88,556	0		4.11
4.12	-171,607	0		4.12
4.13	-96,550	0		4.13
4.14	-20,002,801	0		4.14
4.15	-2,318,090	0		4.15
4.16	-394,898	0		4.16
4.17	-339,619	0		4.17
4.18	-92,772	0		4.18
4.19	-11,592	0		4.19
4.20	-115,729	0		4.20
4.21	-24,327	0		4.21
4.22	563,977	0		4.22
4.23	422,639	0		4.23
4.24	2,489,682	0		4.24
4.25	1,309,703	0		4.25
4.26	1,982,436	0		4.26
4.27	644,850	0		4.27
4.28	144,927	0		4.28
4.29	657,263	0		4.29
4.30	3,406,236	0		4.30
4.31	-149,862	0		4.31
4.32	2,252,004	0		4.32
4.33	246,881	0		4.33
4.34	-690,631	0		4.34
4.35	-835,464	0		4.35
4.36	-1,875,796	0		4.36
4.37	-72,966	0		4.37
4.38	425,633	0		4.38
4.39	-213,697	0		4.39
4.40	0	0		4.40
5.00	-31,873,222			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	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00	IMAGING CENTER		8.00
9.00	SURGICAL CENTER		9.00
10.00			10.00
100.00			100.00

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

Provider CCN: 150109

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2013 2:40 pm

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

(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: 150109

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2013 2:40 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	5.06	OTHER ADMINSTRATIVE AND GENERAL	38,500	0	38,500	171,400	240	1.00
2.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	39,300	0	39,300	171,400	232	2.00
3.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	1,269,493	578,193	691,300	171,400	13,524	3.00
4.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	59,167	0	59,167	171,400	874	4.00
5.00	15.00	PHARMACY	5,400	0	5,400	171,400	47	5.00
6.00	30.00	ADULTS & PEDIATRICS	15,788	0	15,788	154,100	232	6.00
7.00	35.00	NEONATAL INTENSIVE CARE UNIT	264,000	156,000	108,000	152,100	766	7.00
8.00	41.00	SUBPROVIDER - IRF	89,880	0	89,880	171,400	1,142	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	45,837	0	45,837	231,100	237	9.00
10.00	60.00	LABORATORY	112,000	0	112,000	219,500	660	10.00
11.00	65.00	RESPIRATORY THERAPY	35,700	0	35,700	171,400	216	11.00
12.00	69.00	ELECTROCARDIOLOGY	2,663	0	2,663	171,400	18	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	16,513	0	16,513	171,400	180	13.00
14.00	73.01	DIABETES CENTER	8,250	0	8,250	171,400	156	14.00
15.00	91.00	EMERGENCY	159,996	0	159,996	171,400	1,056	15.00
200.00			2,162,487	734,193	1,428,294		19,580	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	5.06	OTHER ADMINSTRATIVE AND GENERAL	19,777	989	0	0	0	1.00
2.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	19,118	956	0	0	0	2.00
3.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	1,114,430	55,722	0	0	0	3.00
4.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	72,021	3,601	0	0	0	4.00
5.00	15.00	PHARMACY	3,873	194	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	17,188	859	0	0	0	6.00
7.00	35.00	NEONATAL INTENSIVE CARE UNIT	56,014	2,801	0	0	0	7.00
8.00	41.00	SUBPROVIDER - IRF	94,105	4,705	0	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	26,332	1,317	0	0	0	9.00
10.00	60.00	LABORATORY	69,649	3,482	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	17,799	890	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	1,483	74	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	14,833	742	0	0	0	13.00
14.00	73.01	DIABETES CENTER	12,855	643	0	0	0	14.00
15.00	91.00	EMERGENCY	87,018	4,351	0	0	0	15.00
200.00			1,626,495	81,326	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	0	19,777	18,723	18,723	1.00
2.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	0	19,118	20,182	20,182	2.00
3.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	0	1,114,430	0	578,193	3.00
4.00	5.06	OTHER ADMINSTRATIVE AND GENERAL	0	72,021	0	0	4.00
5.00	15.00	PHARMACY	0	3,873	1,527	1,527	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	17,188	0	0	6.00
7.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	56,014	51,986	207,986	7.00
8.00	41.00	SUBPROVIDER - IRF	0	94,105	0	0	8.00
9.00	54.00	RADIOLOGY-DIAGNOSTIC	0	26,332	19,505	19,505	9.00
10.00	60.00	LABORATORY	0	69,649	42,351	42,351	10.00
11.00	65.00	RESPIRATORY THERAPY	0	17,799	17,901	17,901	11.00
12.00	69.00	ELECTROCARDIOLOGY	0	1,483	1,180	1,180	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	14,833	1,680	1,680	13.00
14.00	73.01	DIABETES CENTER	0	12,855	0	0	14.00
15.00	91.00	EMERGENCY	0	87,018	72,978	72,978	15.00
200.00			0	1,626,495	248,013	982,206	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	COMMUNICATIONS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	11,328,746	11,328,746			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	8,280,379		8,280,379		2.00
4.00 00400	EMPLOYEE BENEFITS	22,717,894	121,637	89,143	22,928,674	4.00
5.01 00510	COMMUNICATIONS	1,294,682	16,947	12,420	0	1,324,049 5.01
5.02 00511	MGMT INFO SYSTEMS	1,415,981	64,839	47,518	175,475	43,196 5.02
5.03 00512	PURCHASING	796,664	136,446	99,995	211,609	26,293 5.03
5.04 00513	ADMINISTRATIVE	422,639	0	0	167,547	0 5.04
5.05 00514	PATIENT ACCOUNTING	2,489,682	129,840	95,154	346,574	26,293 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	23,897,072	615,144	450,812	2,296,145	137,100 5.06
7.00 00700	OPERATION OF PLANT	8,436,817	1,511,382	1,107,626	969,352	103,295 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	644,850	0	0	46,193	1,878 8.00
9.00 00900	HOUSEKEEPING	1,675,158	165,820	121,522	498,017	16,903 9.00
10.00 01000	DIETARY	959,028	342,225	250,802	251,856	56,343 10.00
11.00 01100	CAFETERIA	735,647	256,892	188,265	413,199	0 11.00
13.00 01300	NURSING ADMINISTRATION	2,104,126	102,524	75,135	822,048	16,903 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	542,378	160,080	117,316	181,727	7,512 14.00
15.00 01500	PHARMACY	3,106,747	139,749	102,416	892,888	43,196 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,679,124	57,962	42,478	450,719	31,927 16.00
17.00 01700	SOCIAL SERVICE	494,393	22,037	16,150	197,869	16,903 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,404,881	2,305,016	1,689,243	3,880,216	215,977 30.00
31.00 03100	INTENSIVE CARE UNIT	289,158	392,688	287,784	115,640	41,318 31.00
35.00 02040	NEONATAL INTENSIVE CARE UNIT	1,915,070	226,219	165,786	735,573	31,927 35.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	1,090,702	0	0	398,423	45,074 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	482,478	79,675	58,390	186,426	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	23,505,712	906,634	664,433	1,379,944	45,074 50.00
51.00 05100	RECOVERY ROOM	703,724	85,847	62,914	282,338	15,025 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,470,548	586,420	429,761	1,372,136	48,830 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,159,881	738,459	541,185	1,527,839	112,685 54.00
56.00 05600	RADIOISOTOPE	1,278,314	289,460	212,133	442,059	0 56.00
60.00 06000	LABORATORY	5,942,662	208,892	153,088	25,613	82,636 60.00
65.00 06500	RESPIRATORY THERAPY	1,322,833	174,889	128,168	477,237	63,855 65.00
66.00 06600	PHYSICAL THERAPY	2,954,410	66,220	48,529	276,928	11,269 66.00
68.00 06800	SPEECH PATHOLOGY	246,881	6,687	4,901	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	613,958	230,929	169,238	372,575	11,269 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	-225,584	8,744	6,408	189,839	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,575,595	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	13,895,376	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,360,360	0	0	0	0 73.00
73.01 07301	DIABETES CENTER	297,460	0	0	114,374	11,269 73.01
74.00 07400	RENAL DIALYSIS	425,633	12,508	9,166	0	0 74.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
88.00 08801	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09001	CLINIC	33,507	0	0	0	60,099 90.00
91.00 09100	EMERGENCY	5,133,695	1,135,966	832,500	2,019,040	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	557,027	0	0	221,186	0 92.01
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	3,270,923	0	0	942,929	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	207,727,211	11,298,777	8,280,379	22,881,533	1,324,049 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,761	29,969	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	39	0	0	0	0 192.00
194.00 07950	MOB	109,705	0	0	44,192	0 194.00
194.01 07951	LIFELINE	41,383	0	0	2,949	0 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part I Date/Time Prepared: 5/29/2013 2:40 pm	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	COMMUNICATIONS
		NEW BLDG & FIXT	NEW MVBLE EQUIP		
202.00	TOTAL (sum lines 118-201)	1.00	2.00	4.00	5.01
202.00	207,912,099	11,328,746	8,280,379	22,928,674	1,324,049
Cost Center Description	MGMT INFO SYSTEMS	PURCHASING	ADMINISTRATIVE	PATIENT ACCOUNTING	Subtotal
	5.02	5.03	5.04	5.05	5A.05
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS				4.00
5.01	00510 COMMUNICATIONS				5.01
5.02	00511 MGMT INFO SYSTEMS	1,747,009			5.02
5.03	00512 PURCHASING	26,280	1,297,287		5.03
5.04	00513 ADMINISTRATIVE	21,323	9	611,518	5.04
5.05	00514 PATIENT ACCOUNTING	46,179	14	0	3,133,736
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	132,988	583	0	0
7.00	00700 OPERATION OF PLANT	101,054	212	0	0
8.00	00800 LAUNDRY & LINEN SERVICE	7,432	51	0	0
9.00	00900 HOUSEKEEPING	80,904	1,119	0	0
10.00	01000 DIETARY	33,766	473	0	0
11.00	01100 CAFETERIA	60,117	448	0	0
13.00	01300 NURSING ADMINISTRATION	46,302	12	0	0
14.00	01400 CENTRAL SERVICES & SUPPLY	22,936	49,456	0	0
15.00	01500 PHARMACY	50,290	3,110	0	0
16.00	01600 MEDICAL RECORDS & LIBRARY	46,040	12	0	0
17.00	01700 SOCIAL SERVICE	16,407	1	0	0
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	280,058	28,363	34,447	176,479
31.00	03100 INTENSIVE CARE UNIT	15,897	21	7,350	37,656
35.00	02040 NEONATAL INTENSIVE CARE UNIT	44,949	3,938	11,943	61,189
40.00	04000 SUBPROVIDER - IPF	0	0	0	0
41.00	04100 SUBPROVIDER - IRF	29,037	1,676	3,194	16,363
42.00	04200 SUBPROVIDER	0	0	0	0
43.00	04300 NURSERY	12,235	23	1,772	9,078
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	97,601	859,306	95,091	487,173
51.00	05100 RECOVERY ROOM	15,926	793	7,600	38,938
52.00	05200 DELIVERY ROOM & LABOR ROOM	90,052	12,283	13,842	70,918
54.00	05400 RADIOLOGY-DIAGNOSTIC	107,752	83,310	109,418	561,347
56.00	05600 RADIO SOTOP	27,670	149,278	40,697	208,501
60.00	06000 LABORATORY	1,754	47,484	51,574	264,226
65.00	06500 RESPIRATORY THERAPY	35,047	12,508	7,823	40,077
66.00	06600 PHYSICAL THERAPY	20,675	608	3,245	16,625
68.00	06800 SPEECH PATHOLOGY	0	0	2,167	11,102
69.00	06900 ELECTROCARDIOLOGY	27,510	955	15,168	77,709
70.00	07000 ELECTROENCEPHALOGRAPHY	13,460	1,203	912	4,675
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	39,303	201,359
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	82,907	424,755
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	34,936	178,987
73.01	07301 DIABETES CENTER	8,973	189	373	1,912
74.00	07400 RENAL DIALYSIS	0	0	475	2,435
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08801 RURAL HEALTH CLINIC	0	0	0	0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09001 CLINIC	1,504	1,076	0	0
91.00	09100 EMERGENCY	141,502	33,889	37,948	194,415
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	12,435	1,743	3,476	17,809
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0	0
101.00	10100 HOME HEALTH AGENCY	63,738	3,109	5,857	30,008
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0	0
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0
111.00	11100 ISLET ACQUISITION	0	0	0	0
113.00	11300 INTEREST EXPENSE				
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,739,793	1,297,255	611,518	3,133,736
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32	0	0
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description			MGMT INFO SYSTEMS	PURCHASING	ADMINITTING	PATIENT ACCOUNTING	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
194.00	07950	MOB	6,659	0	0	0	160,556	194.00
194.01	07951	LIFELINE	557	0	0	0	44,889	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,747,009	1,297,287	611,518	3,133,736	207,912,099	202.00
Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	COMMUNICATIONS						5.01
5.02	00511	MGMT INFO SYSTEMS						5.02
5.03	00512	PURCHASING						5.03
5.04	00513	ADMINITTING						5.04
5.05	00514	PATIENT ACCOUNTING						5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	27,529,844					5.06
7.00	00700	OPERATION OF PLANT	1,866,490	14,096,228				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	106,895	0	807,299			8.00
9.00	00900	HOUSEKEEPING	390,620	267,670	18,438	3,236,171		9.00
10.00	01000	DIETARY	289,136	552,427	21,275	129,280	2,886,611	10.00
11.00	01100	CAFETERIA	252,519	414,681	0	97,044	0	11.00
13.00	01300	NURSING ADMINISTRATION	483,352	165,497	0	38,730	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	165,043	258,405	22,870	60,472	0	14.00
15.00	01500	PHARMACY	662,122	225,586	0	52,792	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	352,285	93,564	0	21,896	0	16.00
17.00	01700	SOCIAL SERVICE	116,564	35,573	0	8,325	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,359,858	3,720,809	302,081	870,747	2,630,080	30.00
31.00	03100	INTENSIVE CARE UNIT	181,237	633,886	44,104	148,343	256,531	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	487,861	365,168	17,871	85,457	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	241,820	0	15,135	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	126,686	128,613	29,370	30,098	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,279,615	1,463,511	139,825	342,492	0	50.00
51.00	05100	RECOVERY ROOM	185,143	138,577	25,712	32,430	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	930,181	946,613	31,402	221,527	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,196,128	1,192,039	45,267	278,962	0	54.00
56.00	05600	RADIOISOTOPE	404,152	467,254	3,242	109,347	0	56.00
60.00	06000	LABORATORY	1,034,441	337,199	5,239	78,912	0	60.00
65.00	06500	RESPIRATORY THERAPY	345,291	282,310	5,641	66,066	0	65.00
66.00	06600	PHYSICAL THERAPY	518,677	106,893	5,589	25,015	0	66.00
68.00	06800	SPEECH PATHOLOGY	41,472	10,794	0	2,526	0	68.00
69.00	06900	ELECTROCARDIOLOGY	231,876	372,772	4,337	87,236	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,116	0	3,303	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,956,004	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,198,177	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	698,122	0	0	0	0	73.00
73.01	07301	DIABETES CENTER	66,321	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	68,712	20,190	0	4,725	0	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08801	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09001	CLINIC	14,680	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,454,300	1,833,704	69,901	429,125	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	124,182	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	658,790	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,488,752	14,047,851	807,299	3,224,850	2,886,611	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,731	48,377	0	11,321	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
194.00	07950	MOB	24,504	0	0	0	0	194.00
194.01	07951	LIFELINE	6,851	0	0	0	0	194.01
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)	27,529,844	14,096,228	807,299	3,236,171	2,886,611	202.00
Cost Center Description			CAFETERIA 11.00	NURSING ADMINISTRATION 13.00	CENTRAL SERVICES & SUPPLY 14.00	PHARMACY 15.00	MEDICAL RECORDS & LIBRARY 16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	COMMUNICATIONS						5.01
5.02	00511	MGMT INFO SYSTEMS						5.02
5.03	00512	PURCHASING						5.03
5.04	00513	ADMINISTRATIVE						5.04
5.05	00514	PATIENT ACCOUNTING						5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	2,418,812					11.00
13.00	01300	NURSING ADMINISTRATION	90,540	3,945,169				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,850	96,311	1,729,356			14.00
15.00	01500	PHARMACY	98,339	0	0	5,377,235		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,028	0	0	0	2,866,035	16.00
17.00	01700	SOCIAL SERVICE	32,084	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	547,633	1,175,990	0	0	161,379	30.00
31.00	03100	INTENSIVE CARE UNIT	31,085	66,752	0	0	34,434	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	87,896	188,747	0	0	55,954	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	56,780	121,929	0	0	14,963	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	23,926	51,378	0	0	8,302	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	190,854	402,623	0	0	445,488	50.00
51.00	05100	RECOVERY ROOM	31,142	66,874	0	0	35,606	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,092	378,139	0	0	64,850	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,702	0	0	0	513,751	54.00
56.00	05600	RADIOISOTOPE	54,108	116,191	0	0	190,661	56.00
60.00	06000	LABORATORY	3,430	0	0	0	241,617	60.00
65.00	06500	RESPIRATORY THERAPY	68,532	147,165	0	0	36,648	65.00
66.00	06600	PHYSICAL THERAPY	40,429	86,817	0	0	15,202	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	10,152	68.00
69.00	06900	ELECTROCARDIOLOGY	53,795	85,249	0	0	71,060	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,320	56,519	0	0	4,275	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	881,972	0	184,130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	847,384	0	388,411	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,377,235	163,672	73.00
73.01	07301	DIABETES CENTER	17,547	37,679	0	0	1,748	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,227	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08801	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09001	CLINIC	2,940	0	0	0	0	90.00
91.00	09100	EMERGENCY	276,699	599,165	0	0	177,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	24,315	0	0	0	16,285	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	124,635	267,641	0	0	27,440	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,404,701	3,945,169	1,729,356	5,377,235	2,866,035	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MOB	13,022	0	0	0	0
194.01	07951	LIFELINE	1,089	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,418,812	3,945,169	1,729,356	5,377,235	2,866,035
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	COMMUNICATIONS					5.01
5.02	00511	MGMT INFO SYSTEMS					5.02
5.03	00512	PURCHASING					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	PATIENT ACCOUNTING					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
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	956,306				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	646,024	35,429,281	0	35,429,281	30.00
31.00	03100	INTENSIVE CARE UNIT	61,819	2,645,703	0	2,645,703	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	82,604	4,568,152	0	4,568,152	35.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	73,002	2,108,098	0	2,108,098	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	92,857	1,321,307	0	1,321,307	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	35,305,376	0	35,305,376	50.00
51.00	05100	RECOVERY ROOM	0	1,728,589	0	1,728,589	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,843,594	0	8,843,594	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,378,725	0	26,378,725	54.00
56.00	05600	RADIOISOTOPE	0	3,993,067	0	3,993,067	56.00
60.00	06000	LABORATORY	0	8,478,767	0	8,478,767	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,214,090	0	3,214,090	65.00
66.00	06600	PHYSICAL THERAPY	0	4,197,131	0	4,197,131	66.00
68.00	06800	SPEECH PATHOLOGY	0	336,682	0	336,682	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,425,636	0	2,425,636	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	104,190	0	104,190	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,838,363	0	15,838,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,837,010	0	17,837,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,813,312	0	10,813,312	73.00
73.01	07301	DIABETES CENTER	0	557,845	0	557,845	73.01
74.00	07400	RENAL DIALYSIS	0	546,071	0	546,071	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09001	CLINIC	0	113,806	0	113,806	90.00
91.00	09100	EMERGENCY	0	14,369,629	0	14,369,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	978,458	0	978,458	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	5,395,070	0	5,395,070	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150109

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	956,306	207,527,952	0	207,527,952	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	133,191	0	133,191	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	45	0	45	192.00
194.00	07950 MOB	0	198,082	0	198,082	194.00
194.01	07951 LIFELINE	0	52,829	0	52,829	194.01
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	956,306	207,912,099	0	207,912,099	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150109

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	314	121,637	89,143	211,094	211,094 4.00
5.01 00510	COMMUNICATIONS	0	16,947	12,420	29,367	0 5.01
5.02 00511	MGMT INFO SYSTEMS	0	64,839	47,518	112,357	1,616 5.02
5.03 00512	PURCHASING	0	136,446	99,995	236,441	1,948 5.03
5.04 00513	ADMITTING	0	0	0	0	1,543 5.04
5.05 00514	PATIENT ACCOUNTING	0	129,840	95,154	224,994	3,191 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	493,871	615,144	450,812	1,559,827	21,142 5.06
7.00 00700	OPERATION OF PLANT	10,120	1,511,382	1,107,626	2,629,128	8,925 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	425 8.00
9.00 00900	HOUSEKEEPING	853	165,820	121,522	288,195	4,585 9.00
10.00 01000	DIETARY	0	342,225	250,802	593,027	2,319 10.00
11.00 01100	CAFETERIA	49,241	256,892	188,265	494,398	3,805 11.00
13.00 01300	NURSING ADMINISTRATION	0	102,524	75,135	177,659	7,569 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	86,068	160,080	117,316	363,464	1,673 14.00
15.00 01500	PHARMACY	50,617	139,749	102,416	292,782	8,221 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	57,962	42,478	100,440	4,150 16.00
17.00 01700	SOCIAL SERVICE	0	22,037	16,150	38,187	1,822 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	272,406	2,305,016	1,689,243	4,266,665	35,705 30.00
31.00 03100	INTENSIVE CARE UNIT	0	392,688	287,784	680,472	1,065 31.00
35.00 02040	NEONATAL INTENSIVE CARE UNIT	0	226,219	165,786	392,005	6,773 35.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	3,668 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	79,675	58,390	138,065	1,717 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	54,993	906,634	664,433	1,626,060	12,706 50.00
51.00 05100	RECOVERY ROOM	0	85,847	62,914	148,761	2,600 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	586,420	429,761	1,016,181	12,634 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	427,876	738,459	541,185	1,707,520	14,068 54.00
56.00 05600	RADIOISOTOPE	29,306	289,460	212,133	530,899	4,070 56.00
60.00 06000	LABORATORY	0	208,892	153,088	361,980	236 60.00
65.00 06500	RESPIRATORY THERAPY	12,862	174,889	128,168	315,919	4,394 65.00
66.00 06600	PHYSICAL THERAPY	0	66,220	48,529	114,749	2,550 66.00
68.00 06800	SPEECH PATHOLOGY	0	6,687	4,901	11,588	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	230,929	169,238	400,167	3,430 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,350	8,744	6,408	16,502	1,748 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
73.01 07301	DIABETES CENTER	0	0	0	0	1,053 73.01
74.00 07400	RENAL DIALYSIS	20,674	12,508	9,166	42,348	0 74.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
88.00 08801	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09001	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	250	1,135,966	832,500	1,968,716	18,590 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	207,108	0	0	207,108	2,037 92.01
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	8,682 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,717,909	11,298,777	8,280,379	21,297,065	210,660 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,969	0	29,969	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	MOB	0	0	0	0	407 194.00
194.01 07951	LIFELINE	0	0	0	0	27 194.01
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)	1,717,909	11,328,746	8,280,379	21,327,034	211,094 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150109

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		COMMUNICATIONS	MGMT INFO SYSTEMS	PURCHASING	ADMINITTING	PATIENT ACCOUNTING	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	COMMUNICATIONS	29,367				5.01
5.02	00511	MGMT INFO SYSTEMS	958	114,931			5.02
5.03	00512	PURCHASING	583	1,729	240,701		5.03
5.04	00513	ADMINITTING	0	1,403	2	2,948	5.04
5.05	00514	PATIENT ACCOUNTING	583	3,038	3	0	231,809
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	3,041	8,749	108	0	0
7.00	00700	OPERATION OF PLANT	2,291	6,648	39	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	42	489	9	0	0
9.00	00900	HOUSEKEEPING	375	5,322	208	0	0
10.00	01000	DIETARY	1,250	2,221	88	0	0
11.00	01100	CAFETERIA	0	3,955	83	0	0
13.00	01300	NURSING ADMINISTRATION	375	3,046	2	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	167	1,509	9,177	0	0
15.00	01500	PHARMACY	958	3,308	577	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	708	3,029	2	0	0
17.00	01700	SOCIAL SERVICE	375	1,079	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,790	18,426	5,263	160	13,058
31.00	03100	INTENSIVE CARE UNIT	916	1,046	4	34	2,786
35.00	02040	NEONATAL INTENSIVE CARE UNIT	708	2,957	731	56	4,527
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	1,000	1,910	311	15	1,211
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	805	4	8	672
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,000	6,421	159,433	442	36,046
51.00	05100	RECOVERY ROOM	333	1,048	147	35	2,881
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,083	5,924	2,279	64	5,247
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,499	7,089	15,458	614	41,478
56.00	05600	RADIOISOTOPE	0	1,820	27,699	189	15,427
60.00	06000	LABORATORY	1,833	115	8,811	240	19,550
65.00	06500	RESPIRATORY THERAPY	1,416	2,306	2,321	36	2,965
66.00	06600	PHYSICAL THERAPY	250	1,360	113	15	1,230
68.00	06800	SPEECH PATHOLOGY	0	0	0	10	821
69.00	06900	ELECTROCARDIOLOGY	250	1,810	177	71	5,750
70.00	07000	ELECTROENCEPHALOGRAPHY	0	885	223	4	346
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	183	14,899
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	386	31,428
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	162	13,243
73.01	07301	DIABETES CENTER	250	590	35	2	141
74.00	07400	RENAL DIALYSIS	0	0	0	2	180
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09001	CLINIC	1,333	99	200	0	0
91.00	09100	EMERGENCY	0	9,309	6,288	177	14,385
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	818	323	16	1,318
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	4,193	577	27	2,220
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,367	114,456	240,695	2,948	231,809
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MOB	0	438	0	0	0
194.01	07951	LIFELINE	0	37	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	29,367	114,931	240,701	2,948	231,809

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150109

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560	1,592,867					5.06
7.00	00700		2,755,020				7.00
8.00	00800	6,185	0	7,150			8.00
9.00	00900	22,600	52,314	163	373,762		9.00
10.00	01000	16,728	107,968	188	14,931	738,720	10.00
11.00	01100	14,610	81,047	0	11,208	0	11.00
13.00	01300	27,965	32,345	0	4,473	0	13.00
14.00	01400	9,549	50,504	203	6,984	0	14.00
15.00	01500	38,308	44,089	0	6,097	0	15.00
16.00	01600	20,382	18,287	0	2,529	0	16.00
17.00	01700	6,744	6,952	0	961	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	194,390	727,208	2,677	100,568	673,070	30.00
31.00	03100	10,486	123,889	391	17,133	65,650	31.00
35.00	02040	28,226	71,370	158	9,870	0	35.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	13,991	0	134	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	7,330	25,137	260	3,476	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	247,688	286,034	1,238	39,556	0	50.00
51.00	05100	10,712	27,084	228	3,745	0	51.00
52.00	05200	53,817	185,010	278	25,585	0	52.00
54.00	05400	184,917	232,977	401	32,219	0	54.00
56.00	05600	23,383	91,322	29	12,629	0	56.00
60.00	06000	59,849	65,903	46	9,114	0	60.00
65.00	06500	19,977	55,176	50	7,630	0	65.00
66.00	06600	30,009	20,892	49	2,889	0	66.00
68.00	06800	2,399	2,110	0	292	0	68.00
69.00	06900	13,416	72,856	38	10,075	0	69.00
70.00	07000	0	2,759	0	382	0	70.00
71.00	07100	113,168	0	0	0	0	71.00
72.00	07200	127,179	0	0	0	0	72.00
73.00	07300	40,391	0	0	0	0	73.00
73.01	07301	3,837	0	0	0	0	73.01
74.00	07400	3,975	3,946	0	546	0	74.00
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09001	849	0	0	0	0	90.00
91.00	09100	84,141	358,386	619	49,562	0	91.00
92.00	09200						92.00
92.01	09201	7,185	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	38,115	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		1,590,490	2,745,565	7,150	372,454	738,720	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	563	9,455	0	1,308	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	1,418	0	0	0	0	194.00
194.01	07951	396	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,592,867	2,755,020	7,150	373,762	738,720	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/29/2013 2:40 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	609,106					11.00
13.00	01300	22,800	276,234				13.00
14.00	01400	11,294	6,744	461,268			14.00
15.00	01500	24,764	0	0	419,104		15.00
16.00	01600	22,671	0	0	0	172,198	16.00
17.00	01700	8,079	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	137,904	82,341	0	0	9,693	30.00
31.00	03100	7,828	4,674	0	0	2,068	31.00
35.00	02040	22,134	13,216	0	0	3,361	35.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	14,298	8,537	0	0	899	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	6,025	3,597	0	0	499	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	48,061	28,191	0	0	26,758	50.00
51.00	05100	7,842	4,682	0	0	2,139	51.00
52.00	05200	44,344	26,477	0	0	3,895	52.00
54.00	05400	53,059	0	0	0	30,908	54.00
56.00	05600	13,625	8,136	0	0	11,452	56.00
60.00	06000	864	0	0	0	14,513	60.00
65.00	06500	17,258	10,304	0	0	2,201	65.00
66.00	06600	10,181	6,079	0	0	913	66.00
68.00	06800	0	0	0	0	610	68.00
69.00	06900	13,547	5,969	0	0	4,268	69.00
70.00	07000	6,628	3,957	0	0	257	70.00
71.00	07100	0	0	235,247	0	11,060	71.00
72.00	07200	0	0	226,021	0	23,330	72.00
73.00	07300	0	0	0	419,104	9,831	73.00
73.01	07301	4,419	2,638	0	0	105	73.01
74.00	07400	0	0	0	0	134	74.00
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09001	740	0	0	0	0	90.00
91.00	09100	69,679	41,952	0	0	10,678	91.00
92.00	09200						92.00
92.01	09201	6,123	0	0	0	978	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	31,386	18,740	0	0	1,648	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		605,553	276,234	461,268	419,104	172,198	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	3,279	0	0	0	0	194.00
194.01	07951	274	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		609,106	276,234	461,268	419,104	172,198	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/29/2013 2:40 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.01	00510	COMMUNICATIONS				5.01
5.02	00511	MGMT INFO SYSTEMS				5.02
5.03	00512	PURCHASING				5.03
5.04	00513	ADMITTING				5.04
5.05	00514	PATIENT ACCOUNTING				5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL				5.06
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	64,199			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,369	6,315,287	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,150	922,592	0	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	5,545	561,637	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,901	50,875	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	6,234	193,829	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,519,634	0	50.00
51.00	05100	RECOVERY ROOM	0	212,237	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,382,818	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,323,207	0	54.00
56.00	05600	RADIOISOTOPE	0	740,680	0	56.00
60.00	06000	LABORATORY	0	543,054	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	441,953	0	65.00
66.00	06600	PHYSICAL THERAPY	0	191,279	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	17,830	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	531,824	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33,691	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	374,557	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	408,344	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	482,731	0	73.00
73.01	07301	DIABETES CENTER	0	13,070	0	73.01
74.00	07400	RENAL DIALYSIS	0	51,131	0	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08801	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09001	CLINIC	0	3,221	0	90.00
91.00	09100	EMERGENCY	0	2,632,482	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	225,906	0	92.01
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	105,588	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,199	21,279,457	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,301	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	MOB	0	5,542	0	194.00
194.01	07951	LIFELINE	0	734	0	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	64,199	21,327,034	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	COMMUNICATIONS (PHONE LINES)	MGMT INFO SYSTEMS (MANHOURS)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	418,458				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		417,351			2.00
4.00 00400	EMPLOYEE BENEFITS	4,493	4,493	56,935,215		4.00
5.01 00510	COMMUNICATIONS	626	626	0	705	5.01
5.02 00511	MGMT INFO SYSTEMS	2,395	2,395	435,731	23	2,114,746
5.03 00512	PURCHASING	5,040	5,040	525,456	14	31,812
5.04 00513	ADMITTING	0	0	416,044	0	25,811
5.05 00514	PATIENT ACCOUNTING	4,796	4,796	860,594	14	55,900
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	22,722	22,722	5,701,662	73	160,981
7.00 00700	OPERATION OF PLANT	55,827	55,827	2,407,041	55	122,325
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	114,705	1	8,997
9.00 00900	HOUSEKEEPING	6,125	6,125	1,236,648	9	97,934
10.00 01000	DIETARY	12,641	12,641	625,394	30	40,874
11.00 01100	CAFETERIA	9,489	9,489	1,026,034	0	72,771
13.00 01300	NURSING ADMINISTRATION	3,787	3,787	2,041,265	9	56,048
14.00 01400	CENTRAL SERVICES & SUPPLY	5,913	5,913	451,255	4	27,764
15.00 01500	PHARMACY	5,162	5,162	2,217,170	23	60,876
16.00 01600	MEDICAL RECORDS & LIBRARY	2,141	2,141	1,119,202	17	55,731
17.00 01700	SOCIAL SERVICE	814	814	491,337	9	19,861
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	85,142	85,142	9,635,114	115	339,008
31.00 03100	INTENSIVE CARE UNIT	14,505	14,505	287,150	22	19,243
35.00 02040	NEONATAL INTENSIVE CARE UNIT	8,356	8,356	1,826,534	17	54,411
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00 04100	SUBPROVIDER - IRF	0	0	989,343	24	35,149
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	2,943	2,943	462,924	0	14,811
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	33,489	33,489	3,426,602	24	118,146
51.00 05100	RECOVERY ROOM	3,171	3,171	701,086	8	19,278
52.00 05200	DELIVERY ROOM & LABOR ROOM	21,661	21,661	3,407,214	26	109,008
54.00 05400	RADIOLOGY-DIAGNOSTIC	27,277	27,277	3,793,848	60	130,433
56.00 05600	RADIOISOTOPE	10,692	10,692	1,097,697	0	33,495
60.00 06000	LABORATORY	7,716	7,716	63,602	44	2,123
65.00 06500	RESPIRATORY THERAPY	6,460	6,460	1,185,050	34	42,424
66.00 06600	PHYSICAL THERAPY	2,446	2,446	687,653	6	25,027
68.00 06800	SPEECH PATHOLOGY	247	247	0	0	0
69.00 06900	ELECTROCARDIOLOGY	8,530	8,530	925,159	6	33,301
70.00 07000	ELECTROENCEPHALOGRAPHY	323	323	471,399	0	16,293
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
73.01 07301	DIABETES CENTER	0	0	284,008	6	10,862
74.00 07400	RENAL DIALYSIS	462	462	0	0	0
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08801	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09001	CLINIC	0	0	0	32	1,820
91.00 09100	EMERGENCY	41,960	41,960	5,013,570	0	171,288
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	549,238	0	15,052
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	2,341,429	0	77,154
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	417,351	417,351	56,818,158	705	2,106,011
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,107	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	MOB	0	0	109,735	0	8,061
194.01 07951	LIFELINE	0	0	7,322	0	674
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	COMMUNICATIONS (PHONE LINES)	MGMT INFO SYSTEMS (MANHOURS)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	11,328,746	8,280,379	22,928,674	1,324,049	1,747,009	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.072600	19.840324	0.402715	1,878.083688	0.826108	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			211,094	29,367	114,931	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003708	41.655319	0.054347	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet B-1	
Date/Time Prepared: 5/29/2013 2:40 pm							
Cost Center Description	PURCHASING (COSTED REQUISITION)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)		
	5.03	5.04	5.05	5A.06	5.06		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS						4.00
5.01 00510	COMMUNICATIONS						5.01
5.02 00511	MGMT INFO SYSTEMS						5.02
5.03 00512	PURCHASING	29,973,165					5.03
5.04 00513	ADMITTING	210	711,291,359				5.04
5.05 00514	PATIENT ACCOUNTING	320	0	711,291,359			5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	13,472	0	0	-27,529,844	180,382,598	5.06
7.00 00700	OPERATION OF PLANT	4,895	0	0	0	12,229,738	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,173	0	0	0	700,404	8.00
9.00 00900	HOUSEKEEPING	25,864	0	0	0	2,559,443	9.00
10.00 01000	DIETARY	10,926	0	0	0	1,894,493	10.00
11.00 01100	CAFETERIA	10,361	0	0	0	1,654,568	11.00
13.00 01300	NURSING ADMINISTRATION	280	0	0	0	3,167,050	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,142,641	0	0	0	1,081,405	14.00
15.00 01500	PHARMACY	71,860	0	0	0	4,338,396	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	286	0	0	0	2,308,262	16.00
17.00 01700	SOCIAL SERVICE	23	0	0	0	763,760	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	655,304	40,054,253	40,054,253	0	22,014,680	30.00
31.00 03100	INTENSIVE CARE UNIT	496	8,546,474	8,546,474	0	1,187,512	31.00
35.00 02040	NEONATAL INTENSIVE CARE UNIT	90,977	13,887,690	13,887,690	0	3,196,594	35.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	38,728	3,713,910	3,713,910	0	1,584,469	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	521	2,060,484	2,060,484	0	830,077	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	19,853,906	110,570,463	110,570,463	0	28,040,968	50.00
51.00 05100	RECOVERY ROOM	18,320	8,837,407	8,837,407	0	1,213,105	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	283,779	16,095,716	16,095,716	0	6,094,790	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,924,819	127,453,547	127,453,547	0	20,941,876	54.00
56.00 05600	RADIOISOTOPE	3,448,962	47,322,148	47,322,148	0	2,648,112	56.00
60.00 06000	LABORATORY	1,097,093	59,969,572	59,969,572	0	6,777,929	60.00
65.00 06500	RESPIRATORY THERAPY	288,985	9,096,058	9,096,058	0	2,262,437	65.00
66.00 06600	PHYSICAL THERAPY	14,052	3,773,248	3,773,248	0	3,398,509	66.00
68.00 06800	SPEECH PATHOLOGY	0	2,519,762	2,519,762	0	271,738	68.00
69.00 06900	ELECTROCARDIOLOGY	22,058	17,637,113	17,637,113	0	1,519,311	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	27,804	1,060,953	1,060,953	343	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,701,071	45,701,071	0	12,816,257	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	96,403,829	96,403,829	0	14,403,038	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	40,623,383	40,623,383	0	4,574,283	73.00
73.01 07301	DIABETES CENTER	4,357	433,956	433,956	0	434,550	73.01
74.00 07400	RENAL DIALYSIS	0	552,629	552,629	0	450,217	74.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00 08801	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09001	CLINIC	24,860	0	0	0	96,186	90.00
91.00 09100	EMERGENCY	782,983	44,125,086	44,125,086	0	9,528,955	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	40,265	4,041,910	4,041,910	0	813,676	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	71,839	6,810,697	6,810,697	0	4,316,564	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,972,419	711,291,359	711,291,359	-27,529,501	180,113,352	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	746	0	0	0	63,762	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	39	192.00
194.00 07950	MOB	0	0	0	0	160,556	194.00
194.01 07951	LIFELINE	0	0	0	0	44,889	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,297,287	611,518	3,133,736		27,529,844	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.043282	0.000860	0.004406		0.152619	203.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150109			Period: From 01/01/2012 To 12/31/2012	Worksheet B-1 Date/Time Prepared: 5/29/2013 2:40 pm	
Cost Center Description		PURCHASING (COSTED REQUISITION)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
204.00	Cost to be allocated (per Wkst. B, Part II)	240,701	2,948	231,809		1,592,867	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.008031	0.000004	0.000326		0.008830	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109

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

Worksheet B-1
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	COMMUNICATIONS					5.01
5.02	00511	MGMT INFO SYSTEMS					5.02
5.03	00512	PURCHASING					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	PATIENT ACCOUNTING					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	322,559				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	870,852			8.00
9.00	00900	HOUSEKEEPING	6,125	19,889	316,434		9.00
10.00	01000	DIETARY	12,641	22,950	12,641	135,840	10.00
11.00	01100	CAFETERIA	9,489	0	9,489	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,787	0	3,787	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,913	24,670	5,913	0	14.00
15.00	01500	PHARMACY	5,162	0	5,162	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,141	0	2,141	0	16.00
17.00	01700	SOCIAL SERVICE	814	0	814	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	85,142	325,863	85,142	123,768	30.00
31.00	03100	INTENSIVE CARE UNIT	14,505	47,576	14,505	12,072	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	8,356	19,278	8,356	0	35.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	16,327	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	2,943	31,682	2,943	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,489	150,832	33,489	0	50.00
51.00	05100	RECOVERY ROOM	3,171	27,736	3,171	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,661	33,874	21,661	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,277	48,831	27,277	0	54.00
56.00	05600	RADIOISOTOPE	10,692	3,497	10,692	0	56.00
60.00	06000	LABORATORY	7,716	5,651	7,716	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,460	6,085	6,460	0	65.00
66.00	06600	PHYSICAL THERAPY	2,446	6,029	2,446	0	66.00
68.00	06800	SPEECH PATHOLOGY	247	0	247	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,530	4,678	8,530	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	323	0	323	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	DIABETES CENTER	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	462	0	462	0	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09001	CLINIC	0	0	0	1,820	90.00
91.00	09100	EMERGENCY	41,960	75,404	41,960	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	171,288	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	15,052	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	77,154	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	321,452	870,852	315,327	1,488,606	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,107	0	1,107	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	8,061	194.00
194.01	07951	LIFELINE	0	0	0	674	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	14,096,228	807,299	3,236,171	2,886,611	2,418,812
203.00		Unit cost multiplier (Wkst. B, Part I)	43.701239	0.927022	10.227002	21.250081	1.615405

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	2,755,020	7,150	373,762	738,720	609,106	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	8.541135	0.008210	1.181169	5.438163	0.406792	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109

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

Worksheet B-1
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,137,292					13.00
14.00	01400	27,764	100				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	711,291,359		16.00
17.00	01700	0	0	0	0	41,133	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	339,008	0	0	40,054,253	27,787	30.00
31.00	03100	19,243	0	0	8,546,474	2,659	31.00
35.00	02040	54,411	0	0	13,887,690	3,553	35.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	35,149	0	0	3,713,910	3,140	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	14,811	0	0	2,060,484	3,994	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	116,066	0	0	110,570,463	0	50.00
51.00	05100	19,278	0	0	8,837,407	0	51.00
52.00	05200	109,008	0	0	16,095,716	0	52.00
54.00	05400	0	0	0	127,453,547	0	54.00
56.00	05600	33,495	0	0	47,322,148	0	56.00
60.00	06000	0	0	0	59,969,572	0	60.00
65.00	06500	42,424	0	0	9,096,058	0	65.00
66.00	06600	25,027	0	0	3,773,248	0	66.00
68.00	06800	0	0	0	2,519,762	0	68.00
69.00	06900	24,575	0	0	17,637,113	0	69.00
70.00	07000	16,293	0	0	1,060,953	0	70.00
71.00	07100	0	51	0	45,701,071	0	71.00
72.00	07200	0	49	0	96,403,829	0	72.00
73.00	07300	0	0	100	40,623,383	0	73.00
73.01	07301	10,862	0	0	433,956	0	73.01
74.00	07400	0	0	0	552,629	0	74.00
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09001	0	0	0	0	0	90.00
91.00	09100	172,724	0	0	44,125,086	0	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	0	0	0	4,041,910	0	92.01
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	77,154	0	0	6,810,697	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		1,137,292	100	100	711,291,359	41,133	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		3,945,169	1,729,356	5,377,235	2,866,035	956,306	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150109

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

Worksheet B-1

Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		(DIRECT NURSING HRS)	(COSTED REQUIS.)				
		13.00	14.00	15.00	16.00	17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	3.468915	17,293.560000	53,772.350000	0.004029	23.249119	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	276,234	461,268	419,104	172,198	64,199	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.242887	4,612.680000	4,191.040000	0.000242	1.560766	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/29/2013 2:40 pm				
			Title XVIII	Hospital	PPS				
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Dissallowance	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	35,429,281		35,429,281	0	35,429,281	40,054,253	30.00
31.00	03100	INTENSIVE CARE UNIT	2,645,703		2,645,703	0	2,645,703	8,546,474	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	4,568,152		4,568,152	51,986	4,620,138	13,887,690	35.00
40.00	04000	SUBPROVIDER - I PF	0		0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	2,108,098		2,108,098	0	2,108,098	3,713,910	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	1,321,307		1,321,307	0	1,321,307	2,060,484	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	35,305,376		35,305,376	0	35,305,376	37,101,879	50.00
51.00	05100	RECOVERY ROOM	1,728,589		1,728,589	0	1,728,589	4,143,488	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,843,594		8,843,594	0	8,843,594	15,165,561	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,378,725		26,378,725	19,505	26,398,230	27,375,951	54.00
56.00	05600	RADIOISOTOPE	3,993,067		3,993,067	0	3,993,067	26,857,976	56.00
60.00	06000	LABORATORY	8,478,767		8,478,767	42,351	8,521,118	29,839,309	60.00
65.00	06500	RESPIRATORY THERAPY	3,214,090	0	3,214,090	17,901	3,231,991	7,410,847	65.00
66.00	06600	PHYSICAL THERAPY	4,197,131	0	4,197,131	0	4,197,131	3,509,990	66.00
68.00	06800	SPEECH PATHOLOGY	336,682	0	336,682	0	336,682	2,459,253	68.00
69.00	06900	ELECTROCARDIOLOGY	2,425,636		2,425,636	1,180	2,426,816	6,067,023	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	104,190		104,190	1,680	105,870	490,901	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,838,363		15,838,363	0	15,838,363	27,715,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,837,010		17,837,010	0	17,837,010	77,074,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,813,312		10,813,312	0	10,813,312	26,316,008	73.00
73.01	07301	DIABETES CENTER	557,845		557,845	0	557,845	58,654	73.01
74.00	07400	RENAL DIALYSIS	546,071		546,071	0	546,071	552,629	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08801	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09001	CLINIC	113,806		113,806	0	113,806	0	90.00
91.00	09100	EMERGENCY	14,369,629		14,369,629	72,978	14,442,607	6,548,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	978,458		978,458	0	978,458	289,401	92.01
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	5,395,070		5,395,070	0	5,395,070	0	101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	0	113.00
200.00		Subtotal (see instructions)	207,527,952	0	207,527,952	207,581	207,735,533	367,241,048	200.00
201.00		Less Observation Beds	0		0	0	0	0	201.00
202.00		Total (see instructions)	207,527,952	0	207,527,952	207,581	207,735,533	367,241,048	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150109

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	PPS
			Outpatient	Total (col. 6 + col. 7)				
			7.00	8.00	9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		40,054,253				30.00
31.00	03100	INTENSIVE CARE UNIT		8,546,474				31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT		13,887,690				35.00
40.00	04000	SUBPROVIDER - IPF		0				40.00
41.00	04100	SUBPROVIDER - IRF		3,713,910				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		2,060,484				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	73,468,584	110,570,463	0.319302	0.000000	0.319302	50.00
51.00	05100	RECOVERY ROOM	4,693,919	8,837,407	0.195599	0.000000	0.195599	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	930,155	16,095,716	0.549438	0.000000	0.549438	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,077,596	127,453,547	0.206967	0.000000	0.207120	54.00
56.00	05600	RADIOISOTOPE	20,464,172	47,322,148	0.084381	0.000000	0.084381	56.00
60.00	06000	LABORATORY	30,130,263	59,969,572	0.141384	0.000000	0.142091	60.00
65.00	06500	RESPIRATORY THERAPY	1,685,211	9,096,058	0.353350	0.000000	0.355318	65.00
66.00	06600	PHYSICAL THERAPY	263,258	3,773,248	1.112339	0.000000	1.112339	66.00
68.00	06800	SPEECH PATHOLOGY	60,509	2,519,762	0.133617	0.000000	0.133617	68.00
69.00	06900	ELECTROCARDIOLOGY	11,570,090	17,637,113	0.137530	0.000000	0.137597	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	570,052	1,060,953	0.098204	0.000000	0.099788	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,985,087	45,701,071	0.346564	0.000000	0.346564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,329,325	96,403,829	0.185024	0.000000	0.185024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,307,375	40,623,383	0.266184	0.000000	0.266184	73.00
73.01	07301	DIABETES CENTER	375,302	433,956	1.285487	0.000000	1.285487	73.01
74.00	07400	RENAL DIALYSIS	0	552,629	0.988133	0.000000	0.988133	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08801	RURAL HEALTH CLINIC	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09001	CLINIC	0	0	0.000000	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	37,576,207	44,125,086	0.325657	0.000000	0.327311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,752,509	4,041,910	0.242078	0.000000	0.242078	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
101.00	10100	HOME HEALTH AGENCY	6,810,697	6,810,697				101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0				111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	344,050,311	711,291,359				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	344,050,311	711,291,359				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/29/2013 2:40 pm			
			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	35,429,281		0	0	40,054,253	30.00
31.00	03100	INTENSIVE CARE UNIT	2,645,703		0	0	8,546,474	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	4,568,152		0	0	13,887,690	35.00
40.00	04000	SUBPROVIDER - I PF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	2,108,098		0	0	3,713,910	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,321,307		0	0	2,060,484	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,305,376		0	0	37,101,879	50.00
51.00	05100	RECOVERY ROOM	1,728,589		0	0	4,143,488	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,843,594		0	0	15,165,561	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,378,725		0	0	27,375,951	54.00
56.00	05600	RADIOISOTOPE	3,993,067		0	0	26,857,976	56.00
60.00	06000	LABORATORY	8,478,767		0	0	29,839,309	60.00
65.00	06500	RESPIRATORY THERAPY	3,214,090	0	0	0	7,410,847	65.00
66.00	06600	PHYSICAL THERAPY	4,197,131	0	0	0	3,509,990	66.00
68.00	06800	SPEECH PATHOLOGY	336,682	0	0	0	2,459,253	68.00
69.00	06900	ELECTROCARDIOLOGY	2,425,636		0	0	6,067,023	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	104,190		0	0	490,901	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,838,363		0	0	27,715,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,837,010		0	0	77,074,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,813,312		0	0	26,316,008	73.00
73.01	07301	DIABETES CENTER	557,845		0	0	58,654	73.01
74.00	07400	RENAL DIALYSIS	546,071		0	0	552,629	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08801	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09001	CLINIC	113,806		0	0	0	90.00
91.00	09100	EMERGENCY	14,369,629		0	0	6,548,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	978,458		0	0	289,401	92.01
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	5,395,070		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
200.00		Subtotal (see instructions)	207,527,952	0	0	0	367,241,048	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	207,527,952	0	0	0	367,241,048	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150109

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital Cost			
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00							
		9.00	10.00	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		40,054,253					30.00
31.00	03100	INTENSIVE CARE UNIT		8,546,474					31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT		13,887,690					35.00
40.00	04000	SUBPROVIDER - IPF		0					40.00
41.00	04100	SUBPROVIDER - IRF		3,713,910					41.00
42.00	04200	SUBPROVIDER		0					42.00
43.00	04300	NURSERY		2,060,484					43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	73,468,584	110,570,463	0.319302	0.000000	0.000000		50.00
51.00	05100	RECOVERY ROOM	4,693,919	8,837,407	0.195599	0.000000	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	930,155	16,095,716	0.549438	0.000000	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,077,596	127,453,547	0.206967	0.000000	0.000000		54.00
56.00	05600	RADIOISOTOPE	20,464,172	47,322,148	0.084381	0.000000	0.000000		56.00
60.00	06000	LABORATORY	30,130,263	59,969,572	0.141384	0.000000	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	1,685,211	9,096,058	0.353350	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	263,258	3,773,248	1.112339	0.000000	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	60,509	2,519,762	0.133617	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	11,570,090	17,637,113	0.137530	0.000000	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	570,052	1,060,953	0.098204	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,985,087	45,701,071	0.346564	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,329,325	96,403,829	0.185024	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,307,375	40,623,383	0.266184	0.000000	0.000000		73.00
73.01	07301	DIABETES CENTER	375,302	433,956	1.285487	0.000000	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0	552,629	0.988133	0.000000	0.000000		74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08801	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0.000000		89.00
90.00	09001	CLINIC	0	0	0.000000	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	37,576,207	44,125,086	0.325657	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,752,509	4,041,910	0.242078	0.000000	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0					99.10
101.00	10100	HOME HEALTH AGENCY	6,810,697	6,810,697					101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0	0					110.00
111.00	11100	ISLET ACQUISITION	0	0					111.00
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	344,050,311	711,291,359					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	344,050,311	711,291,359					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/29/2013 2:40 pm
--	--	----------------------	---	---

Cost Center Description		Title XVIII			Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00		
30.00	ADULTS & PEDIATRICS	6,315,287	0	6,315,287	27,787	227.27	30.00	
31.00	INTENSIVE CARE UNIT	922,592		922,592	2,659	346.97	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	561,637		561,637	3,553	158.07	35.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	50,875	0	50,875	3,140	16.20	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	193,829		193,829	1,306	148.41	43.00	
200.00	Total (lines 30-199)	8,044,220		8,044,220	38,445		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	11,271	2,561,560					30.00
31.00	INTENSIVE CARE UNIT	1,503	521,496					31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0					35.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	1,801	29,176					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	14,575	3,112,232					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/29/2013 2:40 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,519,634	110,570,463	0.022788	20,454,362	466,114	50.00
51.00	05100 RECOVERY ROOM	212,237	8,837,407	0.024016	2,010,314	48,280	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,382,818	16,095,716	0.085912	10,641	914	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,323,207	127,453,547	0.018228	11,214,740	204,422	54.00
56.00	05600 RADIOISOTOPE	740,680	47,322,148	0.015652	6,024,381	94,294	56.00
60.00	06000 LABORATORY	543,054	59,969,572	0.009055	15,003,371	135,856	60.00
65.00	06500 RESPIRATORY THERAPY	441,953	9,096,058	0.048587	2,446,452	118,866	65.00
66.00	06600 PHYSICAL THERAPY	191,279	3,773,248	0.050693	1,000,928	50,740	66.00
68.00	06800 SPEECH PATHOLOGY	17,830	2,519,762	0.007076	842,734	5,963	68.00
69.00	06900 ELECTROCARDIOLOGY	531,824	17,637,113	0.030154	3,139,681	94,674	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	33,691	1,060,953	0.031755	235,252	7,470	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	374,557	45,701,071	0.008196	19,519,802	159,984	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	408,344	96,403,829	0.004236	37,616,749	159,345	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	482,731	40,623,383	0.011883	11,583,028	137,641	73.00
73.01	07301 DIABETES CENTER	13,070	433,956	0.030118	21,976	662	73.01
74.00	07400 RENAL DIALYSIS	51,131	552,629	0.092523	439,696	40,682	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09001 CLINIC	3,221	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	2,632,482	44,125,086	0.059660	3,750,333	223,745	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	225,906	4,041,910	0.055891	112,230	6,273	92.01
200.00	Total (lines 50-199)	13,129,649	636,217,851		135,426,670	1,955,925	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/29/2013 2:40 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,787	0.00	11,271	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,659	0.00	1,503	0	0	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT	3,553	0.00	0	0	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	0.00	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	3,140	0.00	1,801	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	1,306	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	38,445		14,575	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150109

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01	07301	DIABETES CENTER	0	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08801	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09001	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	0	92.01
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 2:40 pm
--	----------------------	---	--

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
Title XVIII								
Hospital								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	110,570,463	0.000000	0.000000	20,454,362	50.00
51.00	05100	RECOVERY ROOM	0	8,837,407	0.000000	0.000000	2,010,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,095,716	0.000000	0.000000	10,641	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	127,453,547	0.000000	0.000000	11,214,740	54.00
56.00	05600	RADIOISOTOPE	0	47,322,148	0.000000	0.000000	6,024,381	56.00
60.00	06000	LABORATORY	0	59,969,572	0.000000	0.000000	15,003,371	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,096,058	0.000000	0.000000	2,446,452	65.00
66.00	06600	PHYSICAL THERAPY	0	3,773,248	0.000000	0.000000	1,000,928	66.00
68.00	06800	SPEECH PATHOLOGY	0	2,519,762	0.000000	0.000000	842,734	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,637,113	0.000000	0.000000	3,139,681	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,060,953	0.000000	0.000000	235,252	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,701,071	0.000000	0.000000	19,519,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	96,403,829	0.000000	0.000000	37,616,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,623,383	0.000000	0.000000	11,583,028	73.00
73.01	07301	DIABETES CENTER	0	433,956	0.000000	0.000000	21,976	73.01
74.00	07400	RENAL DIALYSIS	0	552,629	0.000000	0.000000	439,696	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08801	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09001	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	44,125,086	0.000000	0.000000	3,750,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	4,041,910	0.000000	0.000000	112,230	92.01
200.00		Total (lines 50-199)	0	636,217,851			135,426,670	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 2:40 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	7,847,529	0	50.00
51.00	05100 RECOVERY ROOM	0	944,469	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,794	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	25,293,350	0	54.00
56.00	05600 RADIOISOTOPE	0	4,931,090	0	56.00
60.00	06000 LABORATORY	0	1,082,804	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	250,254	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,768	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,308,579	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	30,338	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,387,365	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,839,125	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,175,970	0	73.00
73.01	07301 DIABETES CENTER	0	1,828	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08801 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09001 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	7,568,357	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	935,629	0	92.01
200.00	Total (lines 50-199)	0	71,601,249	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 2:40 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	0.319302	7,847,529	0	0	2,505,732	50.00
51.00	05100 RECOVERY ROOM	0.195599	944,469	0	0	184,737	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.549438	2,794	0	0	1,535	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206967	25,293,350	0	0	5,234,889	54.00
56.00	05600 RADIOISOTOPE	0.084381	4,931,090	0	0	416,090	56.00
60.00	06000 LABORATORY	0.141384	1,082,804	0	0	153,091	60.00
65.00	06500 RESPIRATORY THERAPY	0.353350	250,254	0	0	88,427	65.00
66.00	06600 PHYSICAL THERAPY	1.112339	1,768	0	0	1,967	66.00
68.00	06800 SPEECH PATHOLOGY	0.133617	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.137530	4,308,579	0	0	592,559	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.098204	30,338	0	0	2,979	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346564	7,387,365	0	0	2,560,195	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.185024	6,839,125	0	0	1,265,402	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266184	4,175,970	0	0	1,111,576	73.00
73.01	07301 DIABETES CENTER	1.285487	1,828	0	0	2,350	73.01
74.00	07400 RENAL DIALYSIS	0.988133	0	0	0	0	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09001 CLINIC	0.000000				0	90.00
91.00	09100 EMERGENCY	0.325657	7,568,357	0	0	2,464,688	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.242078	935,629	0	0	226,495	92.01
200.00	Subtotal (see instructions)		71,601,249	0	0	16,812,712	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		71,601,249	0	0	16,812,712	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 2:40 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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01 07301 DIABETES CENTER	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS				
88.00 08801 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09001 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
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/29/2013 2:40 pm
		Component CCN: 15T109	Title XVIII	Subprovider - IRF
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,519,634	110,570,463	0.022788	0	0	50.00
51.00	05100 RECOVERY ROOM	212,237	8,837,407	0.024016	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,382,818	16,095,716	0.085912	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,323,207	127,453,547	0.018228	163,469	2,980	54.00
56.00	05600 RADIOISOTOPE	740,680	47,322,148	0.015652	0	0	56.00
60.00	06000 LABORATORY	543,054	59,969,572	0.009055	186,378	1,688	60.00
65.00	06500 RESPIRATORY THERAPY	441,953	9,096,058	0.048587	351,882	17,097	65.00
66.00	06600 PHYSICAL THERAPY	191,279	3,773,248	0.050693	1,832,157	92,878	66.00
68.00	06800 SPEECH PATHOLOGY	17,830	2,519,762	0.007076	150,069	1,062	68.00
69.00	06900 ELECTROCARDIOLOGY	531,824	17,637,113	0.030154	15,132	456	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	33,691	1,060,953	0.031755	4,332	138	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	374,557	45,701,071	0.008196	101,499	832	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	408,344	96,403,829	0.004236	1,164	5	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	482,731	40,623,383	0.011883	403,143	4,791	73.00
73.01	07301 DIABETES CENTER	13,070	433,956	0.030118	1,784	54	73.01
74.00	07400 RENAL DIALYSIS	51,131	552,629	0.092523	17,696	1,637	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08801 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09001 CLINIC	3,221	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	2,632,482	44,125,086	0.059660	6,823	407	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	225,906	4,041,910	0.055891	0	0	92.01
200.00	Total (lines 50-199)	13,129,649	636,217,851		3,235,528	124,025	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150109 Component CCN: 15T109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 2:40 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301 DIABETES CENTER	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00 08801 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09001 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150109 Component CCN: 15T109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 2:40 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	110,570,463	0.000000	0.000000	0	50.00
51.00 05100 RECOVERY ROOM	0	8,837,407	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	16,095,716	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	127,453,547	0.000000	0.000000	163,469	54.00
56.00 05600 RADIOISOTOPE	0	47,322,148	0.000000	0.000000	0	56.00
60.00 06000 LABORATORY	0	59,969,572	0.000000	0.000000	186,378	60.00
65.00 06500 RESPIRATORY THERAPY	0	9,096,058	0.000000	0.000000	351,882	65.00
66.00 06600 PHYSICAL THERAPY	0	3,773,248	0.000000	0.000000	1,832,157	66.00
68.00 06800 SPEECH PATHOLOGY	0	2,519,762	0.000000	0.000000	150,069	68.00
69.00 06900 ELECTROCARDIOLOGY	0	17,637,113	0.000000	0.000000	15,132	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,060,953	0.000000	0.000000	4,332	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,701,071	0.000000	0.000000	101,499	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	96,403,829	0.000000	0.000000	1,164	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	40,623,383	0.000000	0.000000	403,143	73.00
73.01 07301 DIABETES CENTER	0	433,956	0.000000	0.000000	1,784	73.01
74.00 07400 RENAL DIALYSIS	0	552,629	0.000000	0.000000	17,696	74.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00 08801 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09001 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	44,125,086	0.000000	0.000000	6,823	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	4,041,910	0.000000	0.000000	0	92.01
200.00 Total (lines 50-199)	0	636,217,851			3,235,528	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150109 Component CCN: 15T109	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 2:40 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	56.00
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01 07301 DIABETES CENTER	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
88.00 08801 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09001 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2013 2:40 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)		27,787	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,787	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)		27,787	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)		11,271	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)		35,429,281	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)		35,429,281	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		40,054,253	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		40,054,253	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.884532	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)		1,441.47	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)		35,429,281	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)		1,275.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,370,863	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)		14,370,863	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,645,703	2,659	995.00	1,503	1,495,485	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	NEONATAL INTENSIVE CARE UNIT	4,620,138	3,553	1,300.35	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					32,969,394	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					48,835,742	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)					3,083,056	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,955,925	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,038,981	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					43,796,761	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	6,315,287	35,429,281	0.178250	0	0	90.00
91.00	Nursing School cost	0	35,429,281	0.000000	0	0	91.00
92.00	Allied health cost	0	35,429,281	0.000000	0	0	92.00
93.00	All other Medical Education	0	35,429,281	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 15T109		Date/Time Prepared: 5/29/2013 2:40 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,140	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,140	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,140	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)		1,801	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)		2,108,098	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)		2,108,098	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,713,910	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,713,910	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.567622	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)		1,182.77	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)		2,108,098	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)		671.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,209,137	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)		1,209,137	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 15T109				Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	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 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0		47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,410,630		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,619,767		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)					29,176		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					124,025		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					153,201		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					3,466,566		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109 Component CCN: 15T109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 2:40 pm		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
	1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00	Capital-related cost	50,875	2,108,098	0.024133	0	0	90.00	
91.00	Nursing School cost	0	2,108,098	0.000000	0	0	91.00	
92.00	Allied health cost	0	2,108,098	0.000000	0	0	92.00	
93.00	All other Medical Education	0	2,108,098	0.000000	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2013 2:40 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)		27,787	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,787	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)		27,787	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,628	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)		1,306	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)		35,429,281	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)		35,429,281	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		40,054,253	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		40,054,253	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.884532	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)		1,441.47	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)		35,429,281	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)		1,275.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,625,809	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)		4,625,809	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 2:40 pm	
Cost Center Description			Title XIX		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1,321,307	1,306	1,011.72	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,645,703	2,659	995.00	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	NEONATAL INTENSIVE CARE UNIT	4,568,152	3,553	1,285.72	0	47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				5,430,652	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				10,056,461	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)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 2:40 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	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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 15T109		Date/Time Prepared: 5/29/2013 2:40 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,140	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,140	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,140	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)		230	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)		1,306	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)		2,108,098	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)		2,108,098	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,713,910	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,713,910	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.567622	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)		1,182.77	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)		2,108,098	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)		671.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		154,415	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)		154,415	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 15T109				Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	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 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0		47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					325,960		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					480,375		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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150109 Component CCN: 15T109		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XIX		Subprovider - IRF		Cost	
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	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: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 2:40 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		18,660,796		30.00
31.00	03100 INTENSIVE CARE UNIT		4,697,288		31.00
35.00	02040 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - I PF		0		40.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.319302	20,454,362	6,531,119	50.00
51.00	05100 RECOVERY ROOM	0.195599	2,010,314	393,215	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.549438	10,641	5,847	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207120	11,214,740	2,322,797	54.00
56.00	05600 RADIOISOTOPE	0.084381	6,024,381	508,343	56.00
60.00	06000 LABORATORY	0.142091	15,003,371	2,131,844	60.00
65.00	06500 RESPIRATORY THERAPY	0.355318	2,446,452	869,268	65.00
66.00	06600 PHYSICAL THERAPY	1.112339	1,000,928	1,113,371	66.00
68.00	06800 SPEECH PATHOLOGY	0.133617	842,734	112,604	68.00
69.00	06900 ELECTROCARDIOLOGY	0.137597	3,139,681	432,011	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.099788	235,252	23,475	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346564	19,519,802	6,764,861	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.185024	37,616,749	6,960,001	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266184	11,583,028	3,083,217	73.00
73.01	07301 DIABETES CENTER	1.285487	21,976	28,250	73.01
74.00	07400 RENAL DIALYSIS	0.988133	439,696	434,478	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08801 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09001 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.327311	3,750,333	1,227,525	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.242078	112,230	27,168	92.01
200.00	Total (sum of lines 50-94 and 96-98)		135,426,670	32,969,394	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)		135,426,670		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15T109		Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XVIII	Subprovider - IRF	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
35.00	02040 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,117,243		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	0.319302	0	0	50.00
51.00	05100 RECOVERY ROOM	0.195599	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.549438	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207120	163,469	33,858	54.00
56.00	05600 RADIOISOTOPE	0.084381	0	0	56.00
60.00	06000 LABORATORY	0.142091	186,378	26,483	60.00
65.00	06500 RESPIRATORY THERAPY	0.355318	351,882	125,030	65.00
66.00	06600 PHYSICAL THERAPY	1.112339	1,832,157	2,037,980	66.00
68.00	06800 SPEECH PATHOLOGY	0.133617	150,069	20,052	68.00
69.00	06900 ELECTROCARDIOLOGY	0.137597	15,132	2,082	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.099788	4,332	432	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346564	101,499	35,176	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.185024	1,164	215	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266184	403,143	107,310	73.00
73.01	07301 DIABETES CENTER	1.285487	1,784	2,293	73.01
74.00	07400 RENAL DIALYSIS	0.988133	17,696	17,486	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08801 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09001 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.327311	6,823	2,233	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.242078	0	0	92.01
200.00	Total (sum of lines 50-94 and 96-98)		3,235,528	2,410,630	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)		3,235,528		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 2:40 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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		10,686,996	30.00
31.00	03100	INTENSIVE CARE UNIT		808,308	31.00
35.00	02040	NEONATAL INTENSIVE CARE UNIT		8,309,143	35.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RF		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	0.319302	2,567,170	50.00
51.00	05100	RECOVERY ROOM	0.195599	232,207	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.549438	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206967	2,306,726	54.00
56.00	05600	RADIOISOTOPE	0.084381	719,488	56.00
60.00	06000	LABORATORY	0.141384	3,622,279	60.00
65.00	06500	RESPIRATORY THERAPY	0.353350	741,755	65.00
66.00	06600	PHYSICAL THERAPY	1.112339	181,209	66.00
68.00	06800	SPEECH PATHOLOGY	0.133617	39,831	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137530	539,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.098204	64,123	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346564	3,486,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.185024	3,142,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266184	3,664,503	73.00
73.01	07301	DIABETES CENTER	1.285487	3,379	73.01
74.00	07400	RENAL DIALYSIS	0.988133	15,484	74.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08801	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09001	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.325657	515,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.242078	54,180	92.01
200.00		Total (sum of lines 50-94 and 96-98)		21,896,500	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)		21,896,500	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15T109		Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XIX	Subprovider - IRF	Cost	
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
35.00	02040 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		315,022		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	0.319302	0	0	50.00
51.00	05100 RECOVERY ROOM	0.195599	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.549438	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206967	9,029	1,869	54.00
56.00	05600 RADIOISOTOPE	0.084381	0	0	56.00
60.00	06000 LABORATORY	0.141384	55,300	7,819	60.00
65.00	06500 RESPIRATORY THERAPY	0.353350	13,259	4,685	65.00
66.00	06600 PHYSICAL THERAPY	1.112339	257,911	286,884	66.00
68.00	06800 SPEECH PATHOLOGY	0.133617	35,269	4,713	68.00
69.00	06900 ELECTROCARDIOLOGY	0.137530	928	128	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.098204	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.346564	13,725	4,757	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.185024	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266184	56,057	14,921	73.00
73.01	07301 DIABETES CENTER	1.285487	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.988133	186	184	74.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08801 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09001 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.325657	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.242078	0	0	92.01
200.00	Total (sum of lines 50-94 and 96-98)		441,664	325,960	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)		441,664		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 2:40 pm
		Title VIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		29,145,802	1.00
2.00	Outlier payments for discharges. (see instructions)		1,821,998	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		3,859,383	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		164.00	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)		3.49	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		24.67	31.00
32.00	Sum of lines 30 and 31		28.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.44	33.00
34.00	Disproportionate share adjustment (see instructions)		3,625,738	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)		34,593,538	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		34,593,538	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		2,863,090	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: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 2:40 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)			37,456,628 59.00
60.00	Primary payer payments			2,123 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			37,454,505 61.00
62.00	Deductibles billed to program beneficiaries			2,740,317 62.00
63.00	Coinurance billed to program beneficiaries			39,575 63.00
64.00	Allowable bad debts (see instructions)			184,355 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			129,049 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			36,696 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			34,803,662 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)			-2,222 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			34,801,440 71.00
72.00	Interim payments			35,310,471 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)			-509,031 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			125,340 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: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 2:40 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)		16,812,712	2.00
3.00	PPS payments		12,312,222	3.00
4.00	Outlier payment (see instructions)		236,348	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.923	5.00
6.00	Line 2 times line 5		15,518,133	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		80.86	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		12,548,570	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)		2,738,237	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)		9,810,333	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)		9,810,333	30.00
31.00	Primary payer payments		5,474	31.00
32.00	Subtotal (line 30 minus line 31)		9,804,859	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)		244,664	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		171,265	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		123,033	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		9,976,124	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		9,976,124	40.00
41.00	Interim payments		10,075,059	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)		-98,935	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		25,043	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: 150109

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2013 2:40 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		35,310,471		10,075,059	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)		35,310,471		10,075,059	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		509,031		98,935	6.02	
7.00	Total Medicare program liability (see instructions)		34,801,440		9,976,124	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: 150109
Component CCN: 15T109

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2013 2:40 pm
PPS

Title XVIII

Subprovider -
IRF

		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		2,513,347		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)		2,513,347		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		67,000		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,580,347		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		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/29/2013 2:40 pm
		Component CCN: 15T109	Title XVIIII	Subprovider - IRF
		PPS		
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		2,408,484	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0447	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		144,374	3.00
4.00	Outlier Payments		64,475	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		8.579235	10.00
11.00	Medical Education Adjustment Factor {{{(1 + (line 9/line 10)) raised to the power of .6876 -1}}.		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		2,617,333	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)		0	14.00
15.00	Organ acquisition		0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		2,617,333	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		2,617,333	19.00
20.00	Deductibles		15,028	20.00
21.00	Subtotal (line 19 minus line 20)		2,602,305	21.00
22.00	Coinsurance		21,958	22.00
23.00	Subtotal (line 21 minus line 22)		2,580,347	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		2,580,347	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		2,580,347	32.00
33.00	Interim payments		2,513,347	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)		67,000	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		64,475	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 2:40 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		10,056,461		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)		10,056,461	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)		10,056,461	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		21,896,500	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)		21,896,500	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)		21,896,500	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		11,840,039	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)		10,056,461	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)		10,056,461	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)		10,056,461	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)		10,056,461	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		10,056,461	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)		10,056,461	0	40.00
41.00	Interim payments		10,056,461	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0		43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XIX	Subprovider - IRF	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	480,375			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)	480,375		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)	480,375		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges	441,664		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)	441,664		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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		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)	441,664		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	38,711		0	18.00
19.00	Interns and Residents (see instructions)		0		19.00
20.00	Cost of Teaching Physicians (see instructions)		0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	441,664		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0		22.00
23.00	Outlier payments		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		26.00
27.00	Subtotal (sum of lines 22 through 26)		0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	441,664		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		38,711		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	441,664			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)	441,664		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)	441,664		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)	441,664		0	40.00
41.00	Interim payments	441,664		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0		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: 150109

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

Worksheet G

Date/Time Prepared:
5/29/2013 2:40 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	10,845,000	0	0	0	1.00
2.00	Temporary investments	5,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	45,738,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,308,000	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,839,000	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)	65,735,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	231,821,000	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)	231,821,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,714,000	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	3,063,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,777,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	304,333,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,068,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,476,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	14,104,000	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	3,087,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,735,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,245,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,245,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,980,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	269,353,000				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)	269,353,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	304,333,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150109

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

Worksheet G-1

Date/Time Prepared:
5/29/2013 2:40 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		292,088,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		20,736,000			2.00
3.00	Total (sum of line 1 and line 2)		312,824,000		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)		312,824,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	43,471,000		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)		43,471,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		269,353,000		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: 150109

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2013 2:40 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	76,278,911		76,278,911	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	3,739,114		3,739,114	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	80,018,025		80,018,025	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,491,784		14,491,784	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	NEONATAL INTENSIVE CARE UNIT	0		0	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,491,784		14,491,784	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	94,509,809		94,509,809	17.00
18.00	Ancillary services	332,843,858	431,331,751	764,175,609	18.00
19.00	Outpatient services	0	0	0	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NICU	13,909,268	8,730	13,917,998	27.00
27.01	NON REIMBURSABLE	-2,529,327	76,902	-2,452,425	27.01
27.02	HOSPICE	0	4,121,286	4,121,286	27.02
27.03	HHA	0	6,810,697	6,810,697	27.03
27.04		0	0	0	27.04
27.05		0	0	0	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	438,733,608	442,349,366	881,082,974	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		243,474,421		29.00
30.00	AFFILIATES	53,963,346			30.00
31.00	PHYSICIAN (CORP 44)	55,857,544			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)		109,820,890		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)		353,295,311		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150109

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

Worksheet G-3

Date/Time Prepared:
5/29/2013 2:40 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	881,082,974	1.00
2.00	Less contractual allowances and discounts on patients' accounts	525,291,663	2.00
3.00	Net patient revenues (line 1 minus line 2)	355,791,311	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	353,295,311	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,496,000	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	CAPITATION AND PREMIUM REVENUE	25,000	24.00
24.01	OTHER OPERATING REVENUE	11,124,000	24.01
24.02	EQUITY IN EARNINGS OF INVESTMENTS	6,766,000	24.02
24.03	NET ASSETS RELEASED	331,000	24.03
24.04	INVESTMENT INCOME	230,000	24.04
24.05	CONTRIBUTIONS	57,000	24.05
25.00	Total other income (sum of lines 6-24)	18,533,000	25.00
26.00	Total (line 5 plus line 25)	21,029,000	26.00
27.00	GAIN ON SALE OF ASSET	293,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	293,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	20,736,000	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150109

Period: From 01/01/2012

Worksheet H

HHA CCN: 157124

To 12/31/2012

Date/Time Prepared: 5/29/2013 2:40 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		21,559	21,559	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	603,573	0	14,170	38,685	48,642	705,070
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	567,075	0	64,001	0	0	631,076
7.00	Physical Therapy	384,973	0	45,354	63	54,927	485,317
8.00	Occupational Therapy	149,248	0	16,349	195	1,823	167,615
9.00	Speech Pathology	11,458	0	2,676	0	0	14,134
10.00	Medical Social Services	23,187	0	2,996	0	0	26,183
11.00	Home Health Aide	53,638	0	14,241	0	0	67,879
12.00	Supplies (see instructions)	0	0	0	25,285	43,058	68,343
13.00	Drugs	548,276	0	9,143	520,998	11,336	1,089,753
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	2,341,428	0	168,930	585,226	181,345	3,276,929
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
		7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	21,559	0	21,559		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	705,070	-5,766	699,304		705,070
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	631,076	0	631,076		631,076
7.00	Physical Therapy	0	485,317	0	485,317		485,317
8.00	Occupational Therapy	0	167,615	0	167,615		167,615
9.00	Speech Pathology	0	14,134	0	14,134		14,134
10.00	Medical Social Services	0	26,183	0	26,183		26,183
11.00	Home Health Aide	0	67,879	0	67,879		67,879
12.00	Supplies (see instructions)	0	68,343	0	68,343		68,343
13.00	Drugs	0	1,089,753	-240	1,089,513		1,089,513
14.00	DME	0	0	0	0		0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		0
16.00	Respiratory Therapy	0	0	0	0		0
17.00	Private Duty Nursing	0	0	0	0		0
18.00	Clinic	0	0	0	0		0
19.00	Health Promotion Activities	0	0	0	0		0
20.00	Day Care Program	0	0	0	0		0
21.00	Home Delivered Meals Program	0	0	0	0		0
22.00	Homemaker Service	0	0	0	0		0
23.00	All Others (specify)	0	0	0	0		0
24.00	Total (sum of lines 1-23)	0	3,276,929	-6,006	3,270,923		3,270,923

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet H-1 Part I Date/Time Prepared: 5/29/2013 2:40 pm
		HHA CCN: 157124	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	21,559		21,559		0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	699,304	0	21,559	0	720,863	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	631,076	0	0	0	631,076	6.00
7.00	Physical Therapy	485,317	0	0	0	485,317	7.00
8.00	Occupational Therapy	167,615	0	0	0	167,615	8.00
9.00	Speech Pathology	14,134	0	0	0	14,134	9.00
10.00	Medical Social Services	26,183	0	0	0	26,183	10.00
11.00	Home Health Aide	67,879	0	0	0	67,879	11.00
12.00	Supplies (see instructions)	68,343	0	0	0	68,343	12.00
13.00	Drugs	1,089,513	0	0	0	1,089,513	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,270,923	0	21,559	0	3,270,923	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	720,863					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	178,396	809,472				6.00
7.00	Physical Therapy	137,192	622,509				7.00
8.00	Occupational Therapy	47,382	214,997				8.00
9.00	Speech Pathology	3,995	18,129				9.00
10.00	Medical Social Services	7,402	33,585				10.00
11.00	Home Health Aide	19,188	87,067				11.00
12.00	Supplies (see instructions)	19,320	87,663				12.00
13.00	Drugs	307,988	1,397,501				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		3,270,923				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150109

Period: From 01/01/2012

Worksheet H-1

HHA CCN: 157124

To 12/31/2012

Part II
Date/Time Prepared:
5/29/2013 2:40 pm

Home Health Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		21,559		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	21,559	0	0	-720,863	2,550,060
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	631,076
7.00	Physical Therapy	0	0	0	0	0	485,317
8.00	Occupational Therapy	0	0	0	0	0	167,615
9.00	Speech Pathology	0	0	0	0	0	14,134
10.00	Medical Social Services	0	0	0	0	0	26,183
11.00	Home Health Aide	0	0	0	0	0	67,879
12.00	Supplies (see instructions)	0	0	0	0	0	68,343
13.00	Drugs	0	0	0	0	0	1,089,513
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	21,559	0	0	-720,863	2,550,060
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	21,559	0	0		720,863
26.00	Unit Cost Multiplier	0.000000	1.000000	0.000000	0.000000		0.282685

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150109

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

Worksheet H-2 Part I

HHA CCN: 157124

Date/Time Prepared: 5/29/2013 2:40 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	COMMUNICATIONS	MGMT INFO SYSTEMS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP					
		1.00	2.00					
1.00 Administrative and General	0	0	0	942,929	0	63,738	1.00	
2.00 Skilled Nursing Care	809,472	0	0	0	0	0	2.00	
3.00 Physical Therapy	622,509	0	0	0	0	0	3.00	
4.00 Occupational Therapy	214,997	0	0	0	0	0	4.00	
5.00 Speech Pathology	18,129	0	0	0	0	0	5.00	
6.00 Medical Social Services	33,585	0	0	0	0	0	6.00	
7.00 Home Health Aide	87,067	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	87,663	0	0	0	0	0	8.00	
9.00 Drugs	1,397,501	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	3,270,923	0	0	942,929	0	63,738	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

Cost Center Description	PURCHASING	ADMINISTRATIVE	PATIENT ACCOUNTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
	5.03	5.04	5.05	5A.05	5.06	7.00	
	1.00 Administrative and General	3,109	5,857	30,008	1,045,641	159,585	0
2.00 Skilled Nursing Care	0	0	0	809,472	123,541	0	2.00
3.00 Physical Therapy	0	0	0	622,509	95,007	0	3.00
4.00 Occupational Therapy	0	0	0	214,997	32,813	0	4.00
5.00 Speech Pathology	0	0	0	18,129	2,767	0	5.00
6.00 Medical Social Services	0	0	0	33,585	5,126	0	6.00
7.00 Home Health Aide	0	0	0	87,067	13,288	0	7.00
8.00 Supplies (see instructions)	0	0	0	87,663	13,379	0	8.00
9.00 Drugs	0	0	0	1,397,501	213,284	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	3,109	5,857	30,008	4,316,564	658,790	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150109

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

Worksheet H-2 Part I

HHA CCN: 157124

Date/Time Prepared: 5/29/2013 2:40 pm

Home Health Agency I

PPS

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	124,635	267,641	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	124,635	267,641	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		15.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	27,440	0	1,624,942	0	1,624,942	1.00
2.00	Skilled Nursing Care	0	0	0	933,013	0	933,013	2.00
3.00	Physical Therapy	0	0	0	717,516	0	717,516	3.00
4.00	Occupational Therapy	0	0	0	247,810	0	247,810	4.00
5.00	Speech Pathology	0	0	0	20,896	0	20,896	5.00
6.00	Medical Social Services	0	0	0	38,711	0	38,711	6.00
7.00	Home Health Aide	0	0	0	100,355	0	100,355	7.00
8.00	Supplies (see instructions)	0	0	0	101,042	0	101,042	8.00
9.00	Drugs	0	0	0	1,610,785	0	1,610,785	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	27,440	0	5,395,070	0	5,395,070	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150109

Period:

Worksheet H-2

HHA CCN: 157124

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

Part I
Date/Time Prepared:
5/29/2013 2:40 pm

Home Health
Agency I

PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	402,132	1,335,145		2.00
3.00	Physical Therapy	309,252	1,026,768		3.00
4.00	Occupational Therapy	106,807	354,617		4.00
5.00	Speech Pathology	9,006	29,902		5.00
6.00	Medical Social Services	16,685	55,396		6.00
7.00	Home Health Aide	43,253	143,608		7.00
8.00	Supplies (see instructions)	43,550	144,592		8.00
9.00	Drugs	694,257	2,305,042		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	1,624,942	5,395,070		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.431004			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet H-2 Part II Date/Time Prepared: 5/29/2013 2:40 pm
		HHA CCN: 157124	Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	COMMUNICATIONS (PHONE LINES)	MGMT INFO SYSTEMS (MANHOURS)	PURCHASING (COSTED REQUIREMENTS)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	0	0	2,341,429	0	77,154	71,839	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	2,341,429	0	77,154	71,839	20.00
21.00 Total cost to be allocated	0	0	942,929	0	63,738	3,109	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.402715	0.000000	0.826114	0.043277	22.00
Cost Center Description	ADMINISTRATIVE (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	5.04	5.05	5A.06	5.06	7.00	8.00	
1.00 Administrative and General	6,810,697	6,810,697	0	1,045,641	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	809,472	0	0	2.00
3.00 Physical Therapy	0	0	0	622,509	0	0	3.00
4.00 Occupational Therapy	0	0	0	214,997	0	0	4.00
5.00 Speech Pathology	0	0	0	18,129	0	0	5.00
6.00 Medical Social Services	0	0	0	33,585	0	0	6.00
7.00 Home Health Aide	0	0	0	87,067	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	87,663	0	0	8.00
9.00 Drugs	0	0	0	1,397,501	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	6,810,697	6,810,697		4,316,564	0	0	20.00
21.00 Total cost to be allocated	5,857	30,008		658,790	0	0	21.00
22.00 Unit cost multiplier	0.000860	0.004406		0.152619	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150109 HHA CCN: 157124	Period: From 01/01/2012 To 12/31/2012	Worksheet H-2 Part II Date/Time Prepared: 5/29/2013 2:40 pm
---	---	---	--

Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	9.00	10.00	11.00	13.00	14.00	15.00	
1.00 Administrative and General	0	0	77,154	77,154	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	77,154	77,154	0	0	20.00
21.00 Total cost to be allocated	0	0	124,635	267,641	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	1.615406	3.468919	0.000000	0.000000	22.00
Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)					
	16.00	17.00					
1.00 Administrative and General	6,810,697	0					1.00
2.00 Skilled Nursing Care	0	0					2.00
3.00 Physical Therapy	0	0					3.00
4.00 Occupational Therapy	0	0					4.00
5.00 Speech Pathology	0	0					5.00
6.00 Medical Social Services	0	0					6.00
7.00 Home Health Aide	0	0					7.00
8.00 Supplies (see instructions)	0	0					8.00
9.00 Drugs	0	0					9.00
10.00 DME	0	0					10.00
11.00 Home Dialysis Aide Services	0	0					11.00
12.00 Respiratory Therapy	0	0					12.00
13.00 Private Duty Nursing	0	0					13.00
14.00 Clinic	0	0					14.00
15.00 Health Promotion Activities	0	0					15.00
16.00 Day Care Program	0	0					16.00
17.00 Home Delivered Meals Program	0	0					17.00
18.00 Homemaker Service	0	0					18.00
19.00 All Others (specify)	0	0					19.00
20.00 Total (sum of lines 1-19)	6,810,697	0					20.00
21.00 Total cost to be allocated	27,440	0					21.00
22.00 Unit cost multiplier	0.004029	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 150109	Period: 01/01/2012 To 12/31/2012	Worksheet H-3 Part I Date/Time Prepared: 5/29/2013 2:40 pm		
				HHA CCN: 157124	Title XVIII	Home Health Agency I		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,335,145		1,335,145	7,044	189.54	1.00
2.00	Physical Therapy	3.00	1,026,768	0	1,026,768	4,518	227.26	2.00
3.00	Occupational Therapy	4.00	354,617	0	354,617	1,469	241.40	3.00
4.00	Speech Pathology	5.00	29,902	0	29,902	124	241.15	4.00
5.00	Medical Social Services	6.00	55,396		55,396	142	390.11	5.00
6.00	Home Health Aide	7.00	143,608		143,608	2,033	70.64	6.00
7.00	Total (sum of lines 1-6)		2,945,436	0	2,945,436	15,330		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care	29140	3,014	1,720			8.00	
9.00	Physical Therapy	29140	1,995	1,304			9.00	
10.00	Occupational Therapy	29140	606	408			10.00	
11.00	Speech Pathology	29140	68	7			11.00	
12.00	Medical Social Services	29140	53	51			12.00	
13.00	Home Health Aide	29140	901	901			13.00	
14.00	Total (sum of lines 8-13)		6,637	4,391			14.00	
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	144,592	0	144,592	0	0.000000	15.00
16.00	Cost of Drugs	9.00	2,305,042	0	2,305,042	0	0.000000	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	3,014	1,720	571,274	326,009		1.00	
2.00	Physical Therapy	1,995	1,304	453,384	296,347		2.00	
3.00	Occupational Therapy	606	408	146,288	98,491		3.00	
4.00	Speech Pathology	68	7	16,398	1,688		4.00	
5.00	Medical Social Services	53	51	20,676	19,896		5.00	
6.00	Home Health Aide	901	901	63,647	63,647		6.00	
7.00	Total (sum of lines 1-6)	6,637	4,391	1,271,667	806,078		7.00	
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150109 HHA CCN: 157124		Period: From 01/01/2012 To 12/31/2012		Worksheet H-3 Part I Date/Time Prepared: 5/29/2013 2:40 pm		
				Title XVIII		Home Health Agency I	PPS	
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies		0	0		0	15.00	
16.00	Cost of Drugs		0	0		0	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	897,283					1.00	
2.00	Physical Therapy	749,731					2.00	
3.00	Occupational Therapy	244,779					3.00	
4.00	Speech Pathology	18,086					4.00	
5.00	Medical Social Services	40,572					5.00	
6.00	Home Health Aide	127,294					6.00	
7.00	Total (sum of lines 1-6)	2,077,745					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part II Date/Time Prepared: 5/29/2013 2:40 pm
		HHA CCN: 157124	Title XVIII	Home Health Agency I PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	1.112339	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy			0	0	col. 2, line 4.00	2.00
3.00	Speech Pathology	68.00	0.133617	0	0	col. 2, line 15.00	3.00
4.00	Cost of Medical Supplies	71.00	0.346564	0	0	col. 2, line 16.00	4.00
5.00	Cost of Drugs	73.00	0.266184	0	0	col. 2, line 16.01	5.00
5.01	Cost of Drugs 1	73.01	1.285487	0	0		5.01

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150109 HHA CCN: 157124	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2013 2:40 pm	
		Title XVII I	Home Health Agency I	PPS	
		Part A	Part B	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)		0	0	0 1.00
2.00	Total charges		0	0	0 2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	0 3.00
4.00	Amount 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(b)		0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)		0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)		0	0	0 8.00
9.00	Primary payer amounts		0	0	0 9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)			0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers			1,039,352	691,132 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers			0	2,114 12.00
13.00	Total PPS Reimbursement - LUPA Episodes			8,772	9,801 13.00
14.00	Total PPS Reimbursement - PEP Episodes			3,389	6,436 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	770 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0 16.00
17.00	Total Other Payments			-4,975	0 17.00
18.00	DME Payments			0	0 18.00
19.00	Oxygen Payments			0	0 19.00
20.00	Prosthetic and Orthotic Payments			0	0 20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)				0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)			1,046,538	710,253 22.00
23.00	Excess reasonable cost (from line 8)			0	0 23.00
24.00	Subtotal (line 22 minus line 23)			1,046,538	710,253 24.00
25.00	Coinsurance billed to program patients (from your records)				0 25.00
26.00	Net cost (line 24 minus line 25)			1,046,538	710,253 26.00
27.00	Reimbursable bad debts (from your records)			0	0 27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	0 28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150109 HHA CCN: 157124	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2013 2:40 pm		
		Title XVIII	Home Health Agency I	PPS		
				Part A Services	Part B Services	
				1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)			1,046,538	710,253	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)			1,046,538	710,253	31.00
32.00	Interim payments (see instructions)			1,046,538	710,253	32.00
33.00	Tentative settlement (for contractor use only)			0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)			0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150109	Period: From 01/01/2012	Worksheet H-5
	HHA CCN: 157124	To 12/31/2012	
		Home Health Agency I	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		1,046,538		710,253	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			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			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. H-4, Part II, column as appropriate, line 32)		1,046,538		710,253	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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)		1,046,538		710,253	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 150109 HHA CCN: 157124	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/29/2013 2:40 pm PPS
			Home Health Agency I	
			Contractor Number	Date (Mo/Day/Yr)
		0	1.00	2.00
8.00	Name of Contractor			8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150109	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/29/2013 2:40 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,336,441	1.00
2.00	Capital DRG outlier payments		389,500	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		92.89	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)		3.49	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		24.67	8.00
9.00	Sum of lines 7 and 8		28.16	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.87	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		137,149	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		2,863,090	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